

1
2 UNITED STATES DISTRICT COURT

3 IN THE DISTRICT OF IDAHO

4 - - - - - x Case No. 1:12-cv-00560-BLW
5 SAINT ALPHONSUS MEDICAL CENTER - :
6 NAMPA, INC., TREASURE VALLEY : Bench Trial
7 HOSPITAL LIMITED PARTNERSHIP, SAINT : Witnesses:
8 ALPHONSUS HEALTH SYSTEM, INC., AND : David Argue
9 SAINT ALPHONSUS REGIONAL MEDICAL : William E. Savage
10 CENTER, INC., : Gregory Sonnenberg (Video)
11 Plaintiffs, : Jeffrey Hessing (Video)

12 vs. :

13 ST. LUKE'S HEALTH SYSTEM, LTD., and :
14 ST. LUKE'S REGIONAL MEDICAL CENTER, :
15 LTD., :
16 Defendants. :

17 - - - - - : Case No. 1:13-cv-00116-BLW
18 FEDERAL TRADE COMMISSION; STATE OF :
19 IDAHO, :
20 Plaintiffs, :

21 vs. :

22 ST. LUKE'S HEALTH SYSTEM, LTD.; :
23 SALTZER MEDICAL GROUP, P.A., :
24 Defendants. :
25 - - - - - x

26 * * * SEALED * * *

27 REPORTER'S TRANSCRIPT OF PROCEEDINGS

28 before B. Lynn Winmill, Chief District Judge

29 Held on October 17, 2013

30 Volume 16, Pages 2928 to 3139

31 Tamara I. Hohenleitner

32 Idaho Certified Shorthand Reporter No. 619

33 Registered Professional Reporter

34 Certified Realtime Reporter

35 Federal Certified Realtime Reporter

United States Courts, District of Idaho
550 West Fort Street, Boise, Idaho 83724 (208) 334-1500

2929

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

A P P E A R A N C E S

FOR PLAINTIFFS SAINT ALPHONSUS MEDICAL CENTER-NAMPA, INC.,
SAINT ALPHONSUS HEALTH SYSTEM, INC.,
AND SAINT ALPHONSUS REGIONAL MEDICAL CENTER, INC.

Keely E. Duke
DUKE SCANLAN & HALL, PLLC
1087 W. River Street, Suite 300
Boise, ID 83707

David A. Ettinger
HONIGMAN MILLER SCHWARTZ AND COHN LLP
2290 First National Building
660 Woodward Avenue
Detroit, MI 48226

FOR PLAINTIFF U.S. FEDERAL TRADE COMMISSION

Peter C. Herrick
U.S. FEDERAL TRADE COMMISSION
500 Pennsylvania Ave., N.W.
Washington, DC 20580

J. Thomas Greene
U.S. FEDERAL TRADE COMMISSION
600 Pennsylvania Ave N.W.
Washington, DC 20580

Henry Chao-Lon Su
U.S. FEDERAL TRADE COMMISSION
601 New Jersey Ave., N.W.
Washington, DC 20001

2930

1 A P P E A R A N C E S (Continued)

2

3 **FOR PLAINTIFF STATE OF IDAHO**

4 Eric J. Wilson
5 GODFREY & KAHN, S.C.
6 One East Main Street
7 Suite 500
8 PO Box 2719
9 Madison, WI 53701

10 Brett T. DeLange
11 OFFICE OF ATTORNEY GENERAL, STATE OF IDAHO
12 954 W. Jefferson, 2nd Floor
13 Boise, ID 83720-0010

14

FOR PLAINTIFF TREASURE VALLEY HOSPITAL

15

16 Raymond D. Powers
17 POWERS TOLMAN FARLEY, PLLC
18 PO Box 9756
19 Boise, ID 83707

20

**FOR DEFENDANTS ST. LUKE'S HEALTH SYSTEM, LTD.
AND ST. LUKE'S REGIONAL MEDICAL CENTER, LTD.**

21

22 Jack R. Bierig
23 Ben J. Keith
24 Scott Stein
25 Charles Schafer
SIDLEY AUSTIN
One South Dearborn
Chicago, IL 60603

26

27 J. Walter Sinclair
28 STOEL RIVES
29 101 S. Capitol Boulevard, Suite 1900
30 Boise, ID 83702

31

FOR DEFENDANT SALTZER MEDICAL GROUP

32

33 Brian Kenneth Julian
34 ANDERSON JULIAN & HULL, LLP
35 PO Box 7426
Boise, ID 83707

2931

I N D E X

		PAGE:
	Courtroom open to the public.....	2932
	Courtroom closed to the public.....	2970
	Courtroom open to the public.....	2998
	Courtroom closed to the public.....	3130

DEFENSE ST. LUKE'S HEALTH SYSTEM

W I T N E S S E S

		PAGE:
ARGUE, David		
	Continued Direct Examination by Mr. Stein.....	2932
	Cross-Examination by Mr. Herrick.....	3021
	Cross-Examination by Mr. Ettinger.....	3046
	Redirect Examination by Mr. Stein.....	3064
	Recross-Examination by Mr. Herrick.....	3076
HESSING, Jeffrey (By video)		
	.....	3131
SAVAGE, William E.		
	Direct Examination by Mr. Keith.....	3080
	Cross-Examination by Mr. Ettinger.....	3101
	Cross-Examination by Mr. Wilson.....	3118
	Redirect Examination by Mr. Keith.....	3123
	Recross-Examination by Mr. Ettinger.....	3126
SONNENBERG, Gregory (By video)		
	.....	3129

DEPOSITIONS

P U B L I S H E D

		PAGE:
ARGUE, David	.....	3079
HESSING, Jeffrey	.....	3131
SONNENBERG, Gregory	.....	3128

* * * * *

<p style="text-align: right;">2932</p> <p>1 PROCEEDINGS</p> <p>2 October 17, 2013</p> <p>3 *****COURTROOM OPEN TO THE PUBLIC*****</p> <p>4 THE CLERK: The court will now hear Civil Case</p> <p>5 12-560-S-BLW, Saint Alphonsus Medical Center, Nampa, Inc.,</p> <p>6 versus St. Luke's Health System for Day 16 of a bench trial.</p> <p>7 THE COURT: Dr. Argue -- oh, there you are, sir.</p> <p>8 If you would retake the witness stand, I'll remind you you</p> <p>9 are still under oath.</p> <p>10 Mr. Stein, you may inquire of the witness.</p> <p>11 MR. STEIN: Thank you, Your Honor.</p> <p>12 DAVID ARGUE,</p> <p>13 having been previously duly sworn to tell the whole truth,</p> <p>14 testified as follows:</p> <p>15 CONTINUED DIRECT EXAMINATION</p> <p>16 BY MR. STEIN:</p> <p>17 Q. Good morning, Dr. Argue.</p> <p>18 A. Good morning.</p> <p>19 Q. When we left off yesterday, we were just getting</p> <p>20 into the area of relevant markets. And can you describe for</p> <p>21 the court, to an economist, when we talk about a geographic</p> <p>22 market, what does that refer to?</p> <p>23 A. The geographic market refers to a collection of</p> <p>24 providers that are effectively constraining each other.</p> <p>25 It's a bit of a misnomer to call it a geographic market. It</p>	<p style="text-align: right;">2933</p> <p>1 doesn't refer to a city or a collection of zip codes, but</p> <p>2 it's rather a group of providers.</p> <p>3 Q. Am I correct that you have analyzed the five</p> <p>4 product and geographic markets that have been alleged by the</p> <p>5 plaintiffs; is that right?</p> <p>6 A. Yes.</p> <p>7 Q. And this morning -- or in your testimony today we</p> <p>8 are going to be focusing with respect to geographic markets</p> <p>9 and the market for adult primary care services in Nampa?</p> <p>10 A. That's right.</p> <p>11 Q. Do you agree with the -- with Professor Dranove's</p> <p>12 conclusion that the market for adult primary care services</p> <p>13 is limited to providers in Nampa?</p> <p>14 A. No, I do not. I think that there are additional</p> <p>15 providers beyond those located in Nampa that should be</p> <p>16 include in a properly defined market.</p> <p>17 Q. Now, one of the things Professor Dranove relied</p> <p>18 upon in reaching the conclusion that Nampa is the</p> <p>19 appropriate market is he looked at where -- the patient</p> <p>20 origin data, where individuals in Nampa currently go to</p> <p>21 receive primary care services. Did you also look at the</p> <p>22 patient origin data?</p> <p>23 A. Yes, I did.</p> <p>24 Q. And in his direct examination, Professor Dranove</p> <p>25 criticized your reliance on patient origin data, because he</p>
<p style="text-align: right;">2934</p> <p>1 says, "Where patients currently go to get primary care isn't</p> <p>2 really informative of where they might go to get primary</p> <p>3 care if there were a price increase."</p> <p>4 Do you recall that testimony?</p> <p>5 A. I do.</p> <p>6 Q. What is your response to that?</p> <p>7 A. The patient origin data reflect the choices that</p> <p>8 patients have made of primary care physicians, and it's</p> <p>9 based on a host of characteristics that are important to the</p> <p>10 patients: the past relationship they have with the PCP, it</p> <p>11 may be the recommendations or their perception of quality,</p> <p>12 the location, the price that the patient has to pay out of</p> <p>13 pocket, whether they're in their network, and so forth. And</p> <p>14 what we see in the patient origin data is a geographic</p> <p>15 distribution of patients based on the patients balancing</p> <p>16 these various characteristics.</p> <p>17 Professor Dranove believes that there is a</p> <p>18 distinct difference between those patients who travel for</p> <p>19 PCP services and those patients who don't travel for PCP</p> <p>20 services. And I disagree with that. And I think that</p> <p>21 there's -- if I look at information about substantial flows</p> <p>22 of patients from one community where there are PCPs</p> <p>23 available to another one to receive PCP services and see</p> <p>24 that, at current prices, I think that there is</p> <p>25 reasonable -- it's a reasonable basis to believe that there</p>	<p style="text-align: right;">2935</p> <p>1 may be some additional patients traveling if the prices were</p> <p>2 to increase.</p> <p>3 What this -- this really underscores a fundamental</p> <p>4 difference between Professor Dranove and myself as to the</p> <p>5 sensitivity of patients to changes in the price that they</p> <p>6 face, their out-of-pocket costs. He thinks that the</p> <p>7 patients are effectively insensitive to any change in their</p> <p>8 out-of-pocket costs, so naturally a change in that wouldn't</p> <p>9 cause them to change their travel patterns.</p> <p>10 I've looked at the evidence, and, to me, I see</p> <p>11 quite a different situation; I think that there is evidence</p> <p>12 of patient sensitivity to changes in their out-of-pocket</p> <p>13 prices.</p> <p>14 Q. So when you look at the patient origin data, just</p> <p>15 looking at where Nampa residents, residents in this market</p> <p>16 that plaintiffs propose currently go for care, what does the</p> <p>17 data show?</p> <p>18 A. The data show that about 40 percent of the</p> <p>19 residents of Nampa who are receiving primary care physician</p> <p>20 services choose physicians located outside of Nampa. They</p> <p>21 also show -- and that's a -- excuse me -- that's a -- hold</p> <p>22 on just a second. That 40 percent is a pretty substantial</p> <p>23 number.</p> <p>24 The data also show that the Nampa PCPs rely on</p> <p>25 patients coming in from other areas for about a third of</p>

<p style="text-align: right;">2936</p> <p>1 their patients. Again, that's a substantial flow of</p> <p>2 information -- of patients. We're not talking about just 5</p> <p>3 or 10 percent. And looking at that, a conclusion that I</p> <p>4 would make is that this suggests that the PCPs outside of</p> <p>5 Nampa are, potentially, acceptable alternatives to the Nampa</p> <p>6 PCPs.</p> <p>7 And I used that word "potentially" on purpose</p> <p>8 because it's not definitive. The patient origin data is one</p> <p>9 piece of information. But this is suggesting that other</p> <p>10 users -- or other residents of Nampa may view the outside</p> <p>11 PCPs as relevant or acceptable alternatives. We'll have to</p> <p>12 look a little bit more to see what other information</p> <p>13 supports that.</p> <p>14 Q. So, Dr. Argue, what are we looking at now on</p> <p>15 slide 43?</p> <p>16 A. This is just a basic map of the Treasure Valley</p> <p>17 showing some of the roads and the locations of the primary</p> <p>18 care physician practice sites.</p> <p>19 THE COURT: Could I ask just a question. That 40</p> <p>20 percent and 33 percent, I think we've heard testimony</p> <p>21 that certainly physical proximity is certainly a factor.</p> <p>22 You've mentioned others that are factors that cause patients</p> <p>23 to choose physicians either inside or outside of their home</p> <p>24 community. Is there any studies or -- you indicated that</p> <p>25 you and Dr. Dranove disagree on, I guess, price sensitivity,</p>	<p style="text-align: right;">2937</p> <p>1 the extent to which a somewhat modest increase in price will</p> <p>2 cause patients to change those habits, those patterns that</p> <p>3 have developed. Are there any studies that have, in fact --</p> <p>4 or maybe that's where you're going to go now, but are there</p> <p>5 studies that indicate that, in fact, there is price</p> <p>6 sensitivity?</p> <p>7 The reason I'm concerned about that is I think, in my</p> <p>8 own experience, where I pay a deductible -- and whether</p> <p>9 that's a -- and I don't know, if I were to know that it was</p> <p>10 a \$25 deductible instead of a \$15 deductible, would that</p> <p>11 cause me to drive 5 miles further or not. Is that the kind</p> <p>12 of thing that you're indicating that, in fact, patients are</p> <p>13 sensitive to those kind of changes?</p> <p>14 THE WITNESS: Let me just make sure that I've got</p> <p>15 your question down right. You mentioned a deductible, and,</p> <p>16 to me, that's usually a 500 or \$1,000 deductible. And you</p> <p>17 may have been referring to the copayment, the amount you</p> <p>18 have to pay to each time.</p> <p>19 THE COURT: You're correct. You're correct.</p> <p>20 You're absolutely right. I guess I don't think -- make</p> <p>21 those distinctions.</p> <p>22 THE WITNESS: I understand.</p> <p>23 THE COURT: My copay.</p> <p>24 THE WITNESS: Your copay. There are some studies;</p> <p>25 they're not conclusive. There is one study that I -- I</p>
<p style="text-align: right;">2938</p> <p>1 don't recall the name of the author -- that showed that</p> <p>2 patients would be -- would shift hospitals in response to a</p> <p>3 small change in the copay. There are studies that show that</p> <p>4 they won't. It's not universally chosen. I will be getting</p> <p>5 into some additional discussion of this topic.</p> <p>6 THE COURT: Well, as President Truman commented</p> <p>7 about always trying to find a one-armed economist so that</p> <p>8 instead of on the one hand and the other hand --</p> <p>9 (Laughter.)</p> <p>10 THE WITNESS: I've only got two hands. I can't go</p> <p>11 beyond that.</p> <p>12 THE COURT: All right. Go ahead, Mr. Stein.</p> <p>13 BY MR. STEIN:</p> <p>14 Q. So Dr. Argue, on this map, the primary care</p> <p>15 practice locations are represented by the different</p> <p>16 triangles; is that right?</p> <p>17 A. Yes, that's right.</p> <p>18 Q. And what are we looking at now in the black-shaded</p> <p>19 area?</p> <p>20 A. This area is the primary service area of the Nampa</p> <p>21 PCPs for their -- their adult patients. It's a 75 percent</p> <p>22 service area. Normally I would look at a 90 percent service</p> <p>23 area so that I'm capturing as many of these patients as I</p> <p>24 can. But this is just a collection of zip codes from which</p> <p>25 is the greatest concentration of source for the Nampa PCPs</p>	<p style="text-align: right;">2939</p> <p>1 for drawing their patients. And I focus on the 75 percent</p> <p>2 for particular illustration that we'll go into.</p> <p>3 THE COURT: So this is the closest 75 percent of</p> <p>4 patients to Nampa?</p> <p>5 THE WITNESS: I'm sorry. I wasn't precise in my</p> <p>6 description of that. It's the zip codes that the most</p> <p>7 important sources of patients in terms of the numbers of</p> <p>8 patients that come. So if we sort the zip codes in</p> <p>9 descending order of significance, the Nampa zip codes are</p> <p>10 likely to be at the top of the list, and then it includes</p> <p>11 some Caldwell zip codes, and so forth.</p> <p>12 BY MR. STEIN:</p> <p>13 Q. And the service area that we're looking at, this</p> <p>14 would be for the providers who are in the Nampa service --</p> <p>15 or the plaintiffs' Nampa market?</p> <p>16 A. Yes, that's correct.</p> <p>17 MR. HERRICK: Your Honor, this slide -- I'm sorry</p> <p>18 to interrupt the questioning -- but this slide appears to be</p> <p>19 somewhat different from what we received in advance. I'm</p> <p>20 not sure it makes a material difference. I haven't had a</p> <p>21 chance to fully digest it. I'm just looking at the shading</p> <p>22 on what we have, and it's different.</p> <p>23 THE WITNESS: It -- can I --</p> <p>24 MR. STEIN: I've had him clarify. You have the</p> <p>25 final version. We're going to bring in the other colors, so</p>

<p style="text-align: right;">2940</p> <p>1 it will appear -- this just pulls apart the colors that you</p> <p>2 have.</p> <p>3 THE COURT: They're overlays?</p> <p>4 MR. STEIN: Exactly. So we're going to talk next</p> <p>5 about the different areas, and then it's going to appear as</p> <p>6 it does there.</p> <p>7 MR. HERRICK: Okay.</p> <p>8 THE WITNESS: The printed version shows all the</p> <p>9 layers together. The version on the PowerPoint brings them</p> <p>10 in one at a time.</p> <p>11 BY MR. STEIN:</p> <p>12 Q. So what are we looking at now, Dr. Argue, in the</p> <p>13 pink-shaded area?</p> <p>14 A. The pink-shaded area is the primary service area</p> <p>15 for the PCPs located in Caldwell, same criteria, 75 percent</p> <p>16 sorting those zip codes in descending order. These are the</p> <p>17 zip codes that are the most important for the Caldwell</p> <p>18 providers.</p> <p>19 Q. Sorry. And how about the blue-shaded area?</p> <p>20 A. The blue-shaded area is the same thing for the</p> <p>21 Meridian PCPs. So now we've got here the Caldwell PCPs in</p> <p>22 pink and the Meridian in blue.</p> <p>23 Q. Now, if we go back, the area that was outlined in</p> <p>24 black is now outlined in white. What does this information</p> <p>25 tell you?</p>	<p style="text-align: right;">2941</p> <p>1 A. What I have taken in the outlining in white is the</p> <p>2 Nampa PCPs primary service area that we saw a few slides</p> <p>3 ago, and overlaid that over the primary service area of the</p> <p>4 Caldwell PCPs and the Meridian PCPs. And what it shows is</p> <p>5 that the area, the set of zip codes that is the most</p> <p>6 important for the Meridian PCPs includes part of the Nampa</p> <p>7 service area, and the same thing for the Caldwell PCPs,</p> <p>8 includes part of the Nampa service area. So the primary zip</p> <p>9 codes, the most important zip codes for the Nampa PCPs, are</p> <p>10 fully included in the set of the most important zip codes</p> <p>11 for either the Meridian or the Caldwell PCPs.</p> <p>12 Q. Now, Dr. Argue, you saw on slide 44 this</p> <p>13 demonstrative that Professor Dranove used, right, that he</p> <p>14 called -- I think he called it the "Pac-Man chart"?</p> <p>15 A. Yes.</p> <p>16 Q. And what is your reaction to this chart?</p> <p>17 Professor Dranove relies on this to support his assertion</p> <p>18 that the market is limited to Nampa. Do you reach the same</p> <p>19 conclusion?</p> <p>20 A. No, I did not. He used this -- he called this his</p> <p>21 "bifurcation of the market" evidence. And this is based</p> <p>22 entirely on the same patient origin data that I've been</p> <p>23 working with.</p> <p>24 But when I looked at this map, I had some</p> <p>25 different observations. What struck me first was these four</p>
<p style="text-align: right;">2942</p> <p>1 zip codes that I've circled here. And you can see from</p> <p>2 those pie charts, each of those four zip codes, more than</p> <p>3 half of the patients travel outside of the community to</p> <p>4 another community to receive primary care physician</p> <p>5 services. And it's not accidental that those zip codes are</p> <p>6 the ones along I-84. I-84 is, obviously, an easy</p> <p>7 transportation route for patients to travel to Caldwell or</p> <p>8 from Caldwell to Meridian and even into Boise.</p> <p>9 Q. Dr. Argue, obviously there was a lot of testimony,</p> <p>10 also, throughout this case that patients generally like to</p> <p>11 get care close to home. You're familiar with that?</p> <p>12 A. Yes, I am.</p> <p>13 Q. And how does that affect your argument that the</p> <p>14 Nampa -- that the market should not appropriately be limited</p> <p>15 just to providers in Nampa?</p> <p>16 A. I'm sure it's true that patients like to receive</p> <p>17 primary care services in a convenient location. Many</p> <p>18 patients want to receive their services close to home.</p> <p>19 There are many others who will be happy receiving their</p> <p>20 services close to work. Now, that's -- that's clearly an</p> <p>21 important feature for many patients. It's not, however, the</p> <p>22 antitrust question.</p> <p>23 The antitrust question is if there's a small but</p> <p>24 significant price increase, what would patients do in</p> <p>25 response to that? Some patients may choose to override that</p>	<p style="text-align: right;">2943</p> <p>1 preference and pick a different provider.</p> <p>2 And it's also important to remember this -- that</p> <p>3 this antitrust question is evaluated in the light of the</p> <p>4 critical loss of patients that I talked about yesterday,</p> <p>5 that small loss of patients that would be sufficient to</p> <p>6 defeat a price increase. So it may be that everybody</p> <p>7 prefers to be close to home or work, and with a price</p> <p>8 increase, most people still prefer to be close to home or</p> <p>9 work. But if a small portion of them are willing to switch</p> <p>10 providers, that could be enough to defeat an attempted price</p> <p>11 increase.</p> <p>12 Q. So let's see if we can just talk a little bit</p> <p>13 about how, conceptually, this might work.</p> <p>14 Your Honor, could we just turn the projector off for</p> <p>15 this next slide?</p> <p>16 THE COURT: Yes.</p> <p>17 MR. STEIN: Thank you.</p> <p>18 BY MR. STEIN:</p> <p>19 Q. So, Dr. Argue, can you explain what we're looking</p> <p>20 at here on slide 46?</p> <p>21 A. This is a pie chart that I made out of some data</p> <p>22 that was included in Dr. Dranove's analysis in his report.</p> <p>23 And what Dr. Dranove did was he examined the patients and</p> <p>24 figured out which ones are commuting to work -- these are</p> <p>25 just Nampa residents here -- which of the Nampa residents</p>

<p style="text-align: right;">2944</p> <p>1 are commuting to work, and then determined which ones have</p> <p>2 PCPs located in Nampa or located outside of Nampa.</p> <p>3 You can see in the orange slice of the pie, the 36</p> <p>4 percent, those are the folks who don't commute to work. And</p> <p>5 I'm going to focus more on the other ones, the other two</p> <p>6 slices that add up to 64 percent.</p> <p>7 The red slice, 30 percent of the folks who commute</p> <p>8 out of Nampa and have a PCP out of Nampa, they're the people</p> <p>9 who have a PCP close to where they work. At least that's a</p> <p>10 reasonable interpretation at this point. But what I want to</p> <p>11 focus on is the 34 percent in the bottom slice. These are</p> <p>12 people who work outside of Nampa but have a PCP in Nampa.</p> <p>13 So their PCP is close to their home, but they're working,</p> <p>14 say, in Meridian or Boise.</p> <p>15 THE COURT: Just so -- the 36 percent are those</p> <p>16 who do not commute, and, therefore, you're assuming that,</p> <p>17 all things being equal, they will choose a PCP in Nampa?</p> <p>18 THE WITNESS: This doesn't include any assumptions</p> <p>19 of mine. It's -- and in that 36 percent, I didn't divide it</p> <p>20 between those who have a PCP in Nampa or don't have a PCP in</p> <p>21 Nampa. I wasn't really --</p> <p>22 THE COURT: But, regardless, then, the 30 percent</p> <p>23 are those who commute out of Nampa and also have a primary</p> <p>24 care physician out of Nampa?</p> <p>25 THE WITNESS: That's right.</p>	<p style="text-align: right;">2945</p> <p>1 THE COURT: The 34 percent are those who currently</p> <p>2 commute out of Nampa but still have a primary care physician</p> <p>3 in Nampa; correct?</p> <p>4 THE WITNESS: That's right. That's right. And so</p> <p>5 the question I asked with this data is what -- can we learn</p> <p>6 something about this about possible responses to a price</p> <p>7 increase. And recognizing that people want to have a</p> <p>8 convenient primary care physician, conveniently located</p> <p>9 either close to home or close to work, I looked at that 34</p> <p>10 percent and said, well, let's suppose there was a price</p> <p>11 increase of these primary care physician services in Nampa,</p> <p>12 so all the Nampa physicians raised their prices. Some of</p> <p>13 these patients, or some of these residents who are already</p> <p>14 commuting out of the city could switch to -- conceivably</p> <p>15 switch to a provider located close to their work rather than</p> <p>16 close to their home. It would be equally convenient from</p> <p>17 the proximity to home or proximity to work</p> <p>18 alternative -- I'm not saying this has to happen, but it's a</p> <p>19 possibility that some of those patients who are getting</p> <p>20 their primary care services in Nampa but driving to work</p> <p>21 could just switch to an office closer to their -- or to a</p> <p>22 practice closer to their office.</p> <p>23 Now, I've got the critical loss numbers on here, as</p> <p>24 well, and just put those on there to show that comparison,</p> <p>25 the comparison of the size of the critical loss relative to</p>
<p style="text-align: right;">2946</p> <p>1 the potential pool of people who might be willing to switch</p> <p>2 to a primary care physician that's convenient to their</p> <p>3 office rather than convenient to their home.</p> <p>4 Q. So, Dr. Argue, I know we're going to talk about</p> <p>5 this idea of switching primary care providers later, but, in</p> <p>6 fact, would a -- would a Nampa resident who wanted to</p> <p>7 continue to have primary care in Nampa need to leave Nampa</p> <p>8 in order to switch primary care providers away from Saltzer</p> <p>9 or St. Luke's?</p> <p>10 A. No. If Saltzer or St. Luke's were -- Saltzer and</p> <p>11 St. Luke's were to attempt to increase the price, everybody</p> <p>12 who is receiving primary care -- there's still an option in</p> <p>13 Nampa of primary care services provided by the SAMG PCPs and</p> <p>14 by some other PCPs who are located in Nampa.</p> <p>15 MR. STEIN: Your Honor, I think we can turn the</p> <p>16 projector back on now.</p> <p>17 BY MR. STEIN:</p> <p>18 Q. So what else did you consider besides patient</p> <p>19 origin data, Dr. Argue?</p> <p>20 A. One of the other things I looked at was some of</p> <p>21 the provider contracting experience, and that -- I think</p> <p>22 there are some good examples in there that shows that Nampa</p> <p>23 could not be a properly defined market.</p> <p>24 For example, if Nampa is a market, okay, if the</p> <p>25 PCPs in Nampa are a market, what we would expect to see is</p>	<p style="text-align: right;">2947</p> <p>1 that providers that have high shares -- according to the</p> <p>2 plaintiffs' theory -- providers that have high shares should</p> <p>3 exercise that market power through higher rates. And we</p> <p>4 have an example of that in that Saltzer accounts for eight</p> <p>5 out of the nine pediatricians in Nampa. That's 89 percent</p> <p>6 of the pediatricians. And according to Ms. Powell, Saltzer</p> <p>7 has threatened to quit Blue Cross's network if it didn't get</p> <p>8 higher rates from Blue Cross. And Blue Cross didn't yield,</p> <p>9 didn't give the higher rates. It must have been because</p> <p>10 Blue Cross had an effective or acceptable alternative option</p> <p>11 that it could have steered those patients to somebody other</p> <p>12 than the Saltzer pediatricians.</p> <p>13 And there's an interesting contrast to this in</p> <p>14 some of the testimony of Mr. Crouch, where he talks about</p> <p>15 some specialists in these other submarkets, and I think it</p> <p>16 was orthopedics and I think gastroenterology. Those</p> <p>17 practitioners had also threatened to quit Blue Cross's</p> <p>18 network, and Blue Cross did give them higher rates. It's an</p> <p>19 indication to me that Blue Cross did not have an acceptable</p> <p>20 outside option or alternative in some of these other</p> <p>21 markets.</p> <p>22 So we've got two situations that are, according to</p> <p>23 the plaintiffs' theory, the same, that is, Nampa is a market</p> <p>24 and these other submarkets are -- as described by</p> <p>25 Mr. Crouch -- markets, but Saltzer couldn't exercise market</p>

<p style="text-align: right;">2948</p> <p>1 power in Nampa. It leads me to conclude that Nampa is not</p> <p>2 actually a market, despite the plaintiffs' contention.</p> <p>3 Q. Dr. Argue, a few minutes ago the court asked you</p> <p>4 about studies on the issue of patient sensitivity to pricing</p> <p>5 and whether they'll move. And I think you testified earlier</p> <p>6 yesterday that, at least the Micron example shows, that when</p> <p>7 this new plan was implemented, there was switching of</p> <p>8 providers. Is that right?</p> <p>9 A. Yes.</p> <p>10 Q. So have you analyzed how many Micron enrollees</p> <p>11 switched from Nampa providers to non-Nampa providers in</p> <p>12 response to price increases?</p> <p>13 A. Yes, I looked at that.</p> <p>14 Q. And what does the evidence that you looked at</p> <p>15 show?</p> <p>16 A. Well, this is a Micron slide that shows its use of</p> <p>17 the MHPN and shows that prior to the implementation of the</p> <p>18 new program, the MHPN, the selected group of providers</p> <p>19 accounted for 40 percent of their pediatric volume; whereas,</p> <p>20 afterward it accounted for 80 percent of their pediatric</p> <p>21 volume, showing a big shift from -- toward the MHPN. And I</p> <p>22 looked at this specifically as to Nampa -- this is for</p> <p>23 overall -- and in Nampa that shift we went from 48 percent</p> <p>24 in Nampa to 7 percent in Nampa after Micron put in that new</p> <p>25 plan.</p>	<p style="text-align: right;">2949</p> <p>1 Q. And that's for pediatric services?</p> <p>2 A. That's for pediatric services.</p> <p>3 Q. So, Dr. Argue, after considering the evidence on</p> <p>4 patient origin data and provider contracting, marketing,</p> <p>5 past evidence of patient travel, what conclusions have you</p> <p>6 reached about what the scope of the appropriate market is in</p> <p>7 this case?</p> <p>8 A. It's my opinion that there are enough alternative</p> <p>9 PCPs available for the residents of Nampa that the</p> <p>10 Nampa -- or I guess I'd more accurately describe it as</p> <p>11 competitive constraints on the Nampa PCPs, that those PCPs</p> <p>12 in the other -- in the neighboring communities need to be</p> <p>13 included in the same market as Nampa. Nampa PCPs are simply</p> <p>14 too narrowly defined to be a properly -- a properly defined</p> <p>15 geographic market.</p> <p>16 I went back, and I've talked a lot about Meridian</p> <p>17 and Caldwell PCPs, and I looked at those, analyzed whether</p> <p>18 perhaps the market was Nampa plus Meridian plus Caldwell.</p> <p>19 And I believe that they are -- through the same process, if</p> <p>20 those PCPs attempted to raise prices, they, again, could</p> <p>21 lose the critical loss this time to the providers in west</p> <p>22 Boise, and that's what led me to bring the providers in west</p> <p>23 Boise into the market as well.</p> <p>24 It's this iterative process of evaluating it each</p> <p>25 time: start with Nampa, then I add in Nampa plus Meridian</p>
<p style="text-align: right;">2950</p> <p>1 plus Caldwell, then I add in west Boise, doing the same</p> <p>2 test, trying to get the sense of whether enough patients</p> <p>3 would leave to render a price increase unprofitable.</p> <p>4 Q. Dr. Argue, does that mean that every provider in</p> <p>5 that market is an equal competitive constraint on every</p> <p>6 other; in other words, a provider in west Caldwell is just</p> <p>7 as much of a competitive constraint as a provider in</p> <p>8 east -- on a provider in east Caldwell or Nampa as one in</p> <p>9 western Boise?</p> <p>10 A. No. The providers are differentiated in their</p> <p>11 location, along with other characteristics, but that's not</p> <p>12 the point. The point is in a market definition test, we</p> <p>13 imagine this group of providers, let's say in Nampa or say</p> <p>14 in Nampa, Meridian, and Caldwell, raising their prices by 5</p> <p>15 percent or 10 percent. That's the test, where this is kind</p> <p>16 of an abstract, hypothetical test, they collectively raise</p> <p>17 their prices.</p> <p>18 Now the question is what the likelihood that</p> <p>19 they're going to lose whatever that critical loss is from</p> <p>20 the -- as a result of that price increase. It may be that</p> <p>21 nobody in Caldwell leaves, or nobody in Nampa leaves and</p> <p>22 goes outside of the market, goes to west Boise. But if</p> <p>23 enough patients from one edge of the market, from Meridian,</p> <p>24 were to leave to west Boise to meet that critical loss, then</p> <p>25 it's appropriate to bring those west Boise providers into</p>	<p style="text-align: right;">2951</p> <p>1 the market, as well. It all depends on viewing that market</p> <p>2 as a single unit, as a single -- as all the providers doing</p> <p>3 the same thing together and testing for the potential loss</p> <p>4 of patients.</p> <p>5 Q. And this area that you've described, including</p> <p>6 Nampa, Meridian, Caldwell, western Boise, is that a precise</p> <p>7 geographic market; in other words, did you determine that</p> <p>8 that is all of the providers that might be included?</p> <p>9 A. No. As I indicated yesterday in response to</p> <p>10 Your Honor's question, I didn't define an outside boundary</p> <p>11 of that market. I know that it's not Nampa. I know that</p> <p>12 it's not Nampa, Meridian, and Caldwell. All of those are</p> <p>13 too narrow. I thought that it would be -- it was</p> <p>14 appropriate to test for west Boise, as well. I think that's</p> <p>15 probably still too narrow.</p> <p>16 But, ultimately, it doesn't matter. I'm going to</p> <p>17 go through the competitive effects analysis, which I've</p> <p>18 already done. I mean, I already had looked at this. I was</p> <p>19 looking at these things simultaneously. And it wouldn't</p> <p>20 matter if the market were very broad or fairly narrow, like</p> <p>21 the plaintiff alleges. The competitive effects analysis is</p> <p>22 going to show that, notwithstanding any high shares or</p> <p>23 changes in shares, it's a competitive market. There are</p> <p>24 competitive dynamics that are going to ensure that payors</p> <p>25 receive competitive prices.</p>

<p style="text-align: right;">2952</p> <p>1 Q. So notwithstanding that, Dr. Argue, did you go</p> <p>2 through the mechanical calculation of determining what an</p> <p>3 HHI would be in this area that you've defined?</p> <p>4 A. Yes, I did.</p> <p>5 Q. And what did you determine?</p> <p>6 A. Well, I determined that in the Nampa, Caldwell,</p> <p>7 Meridian, and west Boise, capturing these PCPs, prior to the</p> <p>8 transaction the HHI was 1448, after the transaction the HHI</p> <p>9 was 2180, and that leaves a change of 732. Now, according</p> <p>10 to the terminology from the merger guidelines, that would</p> <p>11 mean that that market, post-transaction, is moderately</p> <p>12 concentrated and that the change in the HHI would,</p> <p>13 potentially, raise some significant competitive concerns.</p> <p>14 Q. And so is that why you move on, then, to a</p> <p>15 competitive effects analysis to determine whether those</p> <p>16 concerns are borne out?</p> <p>17 A. Yeah, absolutely. That's exactly what the merger</p> <p>18 guidelines would tell you to do. If you have high shares</p> <p>19 and high HHI, go on, figure out what else is happening in</p> <p>20 that market that might offset it.</p> <p>21 Q. Now, you testified yesterday that high HHIs are</p> <p>22 not necessarily of concern. And can you explain why that</p> <p>23 is?</p> <p>24 A. What it comes down to is the ability of these two</p> <p>25 systems, the two systems that I started talking about</p>	<p style="text-align: right;">2953</p> <p>1 yesterday, Saint Al's and St. Luke's, to provide competitive</p> <p>2 constraints on each other. And I've got an illustration</p> <p>3 here, just this graphical illustration using Micron. Prior</p> <p>4 to the Micron's new plan it was overwhelmingly St. Luke's</p> <p>5 providing hospital care. Afterwards, it was overwhelmingly</p> <p>6 Saint Al's providing hospital care.</p> <p>7 In each case, the HHI, you know, before -- I'm not</p> <p>8 saying that Micron is a market, but if we can imagine the</p> <p>9 effect of that concentration on Micron's negotiations, the</p> <p>10 HHI was 6250 before. It was 8200 afterward, with a change</p> <p>11 of almost 2000. That's highly concentrated. Yet at neither</p> <p>12 time was Micron forced to accept above-competitive prices.</p> <p>13 It was able to take these two systems, play them off against</p> <p>14 each other in a manner that allowed Micron to get good,</p> <p>15 competitive pricing.</p> <p>16 Q. And how does this fit into this bargaining model</p> <p>17 that you discussed yesterday?</p> <p>18 A. The bargaining model is, again, the health plans</p> <p>19 and the providers sitting down in the conference room trying</p> <p>20 to figure out what their prices are going to be. And as</p> <p>21 long as they are two acceptable, attractive alternatives</p> <p>22 that are competing vigorously for those contracts, the</p> <p>23 payors can be assured that they'll get competitive price.</p> <p>24 It's the competition between those two systems that gives</p> <p>25 the payors leverage in these negotiations.</p>
<p style="text-align: right;">2954</p> <p>1 Q. So, Dr. Argue, let's move on now to your</p> <p>2 discussion of the competitive effects analysis. Can you</p> <p>3 describe generally what types of issues you considered in</p> <p>4 competitive effects analysis?</p> <p>5 A. Certainly. I should start by reminding that the</p> <p>6 competitive effects is a discussion of how the market</p> <p>7 actually works. And I looked at several pieces of evidence.</p> <p>8 One was the availability of the SAMG and other PCPs in</p> <p>9 Nampa. I looked at the very important negotiation dynamics</p> <p>10 between St. Luke's and the payors. I considered the</p> <p>11 patients' alternatives and the choices that they have and</p> <p>12 are making, and I looked at some evidence on pricing, as</p> <p>13 well.</p> <p>14 Q. So we just talked about this a little bit, but</p> <p>15 what did you determine about the availability of alternative</p> <p>16 providers?</p> <p>17 A. The starting point on that is -- in a competitive</p> <p>18 effects analysis is now we're not thinking about the Nampa</p> <p>19 PCPs as a group, but we're thinking about them individually.</p> <p>20 And the key point here is that the Nampa residents do not</p> <p>21 need to change their travel patterns if they want to</p> <p>22 continue to use primary care services in Nampa. They can</p> <p>23 switch to Nampa providers and remain close to their home.</p> <p>24 Q. Now, that assumes, of course, that the other Nampa</p> <p>25 providers, like the SAMG doctors and Primary Health, have</p>	<p style="text-align: right;">2955</p> <p>1 sufficient capacity to take a certain number of patients or</p> <p>2 have shifted to them a certain number of patients in order</p> <p>3 to defeat a price increase; is that right?</p> <p>4 A. That's right. We need to understand whether there</p> <p>5 is some ability for those providers to provide a competitive</p> <p>6 constraint. And it's a competitive constraint that we're</p> <p>7 after. We're not -- again, I'm not talking about everybody</p> <p>8 in Nampa having to switch. It's just enough that could</p> <p>9 switch to discipline an attempted price increase.</p> <p>10 Q. We're going to talk about that later in your</p> <p>11 presentation?</p> <p>12 A. Yes.</p> <p>13 Q. Okay. So what about Professor Dranove's analysis,</p> <p>14 his diversion analysis, where he says -- and I'm</p> <p>15 paraphrasing here -- but, you know, these other providers</p> <p>16 may be alternatives, but they're just less popular. The</p> <p>17 SAMG doctors would be the third choice, and, you know, even</p> <p>18 if patients could switch, you would be forcing them to</p> <p>19 switch to their third choice rather than their second</p> <p>20 choice.</p> <p>21 How do you respond to that?</p> <p>22 A. Right. I recall that testimony of Professor</p> <p>23 Dranove, and he has done this diversion analysis and</p> <p>24 presented it, the detailed data, in his report. And I</p> <p>25 looked at that report and asked the question: If the</p>

<p style="text-align: right;">2956</p> <p>1 Saltzer PCPs in Nampa were not available, where would those</p> <p>2 Nampa residents who want to stay in Nampa go? What</p> <p>3 alternatives would they have for care? And you can run this</p> <p>4 diversion ratio. It's just a mechanical calculation based</p> <p>5 on the patient origin data.</p> <p>6 And what it shows is these two percentages. From</p> <p>7 Saltzer to St. Luke's, the diversion is 15 percent, and from</p> <p>8 Saltzer to Saint Al's Nampa is 12.3 percent. That</p> <p>9 difference, in my experience working with diversion ratios,</p> <p>10 is not significant. That's showing that Saint Al's PCPs in</p> <p>11 Nampa and St. Luke's PCPs in Nampa are virtually</p> <p>12 indistinguishable. They are very close substitutes to each</p> <p>13 other for patients of Saltzer's who want to stay in Nampa.</p> <p>14 Q. Dr. Argue, another focus of Professor Dranove's</p> <p>15 testimony was this theory that, essentially, the transaction</p> <p>16 between Saltzer and St. Luke's is anticompetitive because</p> <p>17 just adding more providers to St. Luke's gives St. Luke's</p> <p>18 more bargaining power or clout when it goes into</p> <p>19 negotiations with payors, and, therefore, you know, just</p> <p>20 that fact is going to lead to higher prices. I hope I've</p> <p>21 accurately captured, essentially, what Dr. Dranove was</p> <p>22 saying.</p> <p>23 And what is your view on that as a predictor of whether</p> <p>24 the transaction is likely to be anticompetitive?</p> <p>25 A. Yes. I recall his testimony on that in his</p>	<p style="text-align: right;">2957</p> <p>1 discussion of this bargaining leverage theory. And I don't</p> <p>2 think it's actually, at least the way he described it is</p> <p>3 very informative as to the antitrust question. It's</p> <p>4 interesting from a bargaining standpoint and from a business</p> <p>5 negotiation standpoint, but it's not really getting at the</p> <p>6 antitrust point.</p> <p>7 But the key is that bargaining strength is</p> <p>8 certainly something that a -- the parties would take into</p> <p>9 consideration when they're going into a negotiation. But it</p> <p>10 alone doesn't tell us whether a transaction is</p> <p>11 anticompetitive. Professor Dranove had concluded that any</p> <p>12 increase in bargaining strength raises prices, and I can</p> <p>13 understand how he gets to that conclusion. But he says</p> <p>14 that's true regardless of whether there is market power, of</p> <p>15 whether the transaction creates market power. He also goes</p> <p>16 on to conclude that, under his theory, any merger of</p> <p>17 providers harms consumers.</p> <p>18 The biggest dispute or the biggest contention I</p> <p>19 have with Professor Dranove's bargaining theory is that</p> <p>20 there's no -- there's no benchmark. There's no objective</p> <p>21 cutoff point at which an increase in bargaining strength</p> <p>22 suddenly becomes a relevant form for determining market</p> <p>23 power. When is it the case that some change -- and</p> <p>24 bargaining strength is affected by a host of</p> <p>25 characteristics. But at what point does that become</p>
<p style="text-align: right;">2958</p> <p>1 significant for an antitrust analysis? It can't be that</p> <p>2 every incremental change in bargaining strength is going to</p> <p>3 cause harm to competition.</p> <p>4 Q. And so as you consider the changes in, you know,</p> <p>5 relative bargaining strength, what role does that play, if</p> <p>6 any, in your analysis of what you view as the antitrust, the</p> <p>7 relevant antitrust question?</p> <p>8 A. I think it's very important to consider both sides</p> <p>9 of the table in this bargaining question. Professor Dranove</p> <p>10 was not especially interested in the provider side. He was</p> <p>11 interested in the payors' perspective. But I think that's a</p> <p>12 mistake. I think it really is a critical omission. The</p> <p>13 transaction cannot create harmful effects if St. Luke's</p> <p>14 cannot risk being excluded from the payors' network. The</p> <p>15 antitrust question is would St. Luke's lose more than the</p> <p>16 critical loss if it were excluded from a network?</p> <p>17 That's -- Professor Dranove talks about exclusion. I talk</p> <p>18 about critical loss. This ties these two together.</p> <p>19 We know something about this, so let's think about</p> <p>20 with Blue Cross. What would St. Luke's risk if it went out</p> <p>21 of network with Blue Cross? It would risk its entire</p> <p>22 volume. And we have testimony from Dr. Pate who says</p> <p>23 St. Luke's couldn't risk it. We have testimony from</p> <p>24 Ms. Powell that Saltzer would not walk away from Blue Cross.</p> <p>25 Neither one of them would take the risk of walking away from</p>	<p style="text-align: right;">2959</p> <p>1 Blue Cross.</p> <p>2 And the reason they wouldn't take that risk is</p> <p>3 because Saint Al's is right there, ready to pick up any lost</p> <p>4 patient volume. Saint Al's can put together -- it's got its</p> <p>5 own network. It's got the Saint Al's Health Alliance, IPN</p> <p>6 is available. All of these networks can be sold without the</p> <p>7 Saltzer-St. Luke's providers and draw some patients off --</p> <p>8 not everybody, not all patients, but it's able to draw some</p> <p>9 of the patients, and it's enough, I think, to exceed the</p> <p>10 critical loss.</p> <p>11 Micron is a classic example of what happened to</p> <p>12 St. Luke's when it walked away from a payor, when it walked</p> <p>13 away from a contract. It said, we're not going to be in</p> <p>14 that network, and this next slide shows the impact.</p> <p>15 Micron's hospital volume went from 20 percent MHPN, that</p> <p>16 would be the Saint Al's hospital, to 75 percent. It was an</p> <p>17 enormous shift of volume away from St. Luke's because it</p> <p>18 walked away from that network. If it did the same thing for</p> <p>19 Blue Cross, it very well could have a similar impact. And</p> <p>20 you don't need an impact anywhere near that magnitude to</p> <p>21 make that price, that outside option, completely untenable</p> <p>22 for St. Luke's.</p> <p>23 THE COURT: Well, I'm not sure I understand</p> <p>24 what -- what does each of these pieces represent? This is a</p> <p>25 Micron Health Partners Network volume report. 75 percent in</p>

<p style="text-align: right;">2960</p> <p>1 the fourth quarter of 2008 was within the network, 25</p> <p>2 percent out. Is that what this shows?</p> <p>3 THE WITNESS: That's right.</p> <p>4 THE COURT: And that would be -- Saint Al's would</p> <p>5 be in and St. Luke's would be out?</p> <p>6 THE WITNESS: That's right. St. Luke's or</p> <p>7 Treasure Valley. Treasure Valley is also not in the MHPN.</p> <p>8 THE COURT: All right.</p> <p>9 BY MR. STEIN:</p> <p>10 Q. St. Luke's is in the green, the green part of the</p> <p>11 bars in these charts?</p> <p>12 A. That's right. St. Luke's is in the green part in</p> <p>13 2007, and St. Luke's is still in the green part in 2008.</p> <p>14 THE COURT: All right.</p> <p>15 BY MR. STEIN:</p> <p>16 Q. So, again, Dr. Argue, getting back to a question</p> <p>17 the court raised about price sensitivity and whether</p> <p>18 patients are going to be able to feel the impact of these</p> <p>19 changes. One thing Professor Dranove says, I think he was</p> <p>20 talking about the fact that, you know, Blue Cross has a</p> <p>21 statewide fee schedule. So maybe St. Luke's and Saltzer</p> <p>22 can't, if they were to try to raise prices, actually get any</p> <p>23 increases in the statewide fee schedule, but they'll push</p> <p>24 that increase somewhere else in the contract. It may be</p> <p>25 spread out over other services, or it will be taken in</p>	<p style="text-align: right;">2961</p> <p>1 hospital services. What's your response to that argument?</p> <p>2 A. I think that argument is inconsistent with the</p> <p>3 plaintiffs' antitrust theory. I think it's inconsistent</p> <p>4 with basic antitrust principles. Professor Dranove was</p> <p>5 talking about a -- or was describing what I would see as an</p> <p>6 academic view on a bargaining perspective. And that's very</p> <p>7 interesting and very helpful, but there was no antitrust</p> <p>8 explanation of how this would work, how the change in the</p> <p>9 share or the concentration or anything in PCP services would</p> <p>10 result in an increase in price. You could see it happening</p> <p>11 if it were to occur in PCP services, but to say that</p> <p>12 St. Luke's is somehow going to increase the price over here</p> <p>13 in imaging services, or something else, doesn't make sense</p> <p>14 to me from an antitrust perspective.</p> <p>15 Let's suppose they did that, let's suppose</p> <p>16 St. Luke's tried to do that and raise the price of their</p> <p>17 imaging services instead. But in imaging, St. Luke's has</p> <p>18 already got the price at the level that would be optimal for</p> <p>19 that. So any increase in that price would cause patients to</p> <p>20 leave.</p> <p>21 It's possible, I suppose, that if this small price</p> <p>22 increase were scattered across a bunch of different services</p> <p>23 that maybe patients might not recognize it, but the health</p> <p>24 plans will, and the health plans will take steps to take</p> <p>25 advantage of the alternatives that are in the other markets,</p>
<p style="text-align: right;">2962</p> <p>1 in the other service areas where the price increase is to</p> <p>2 occur. So it's really, I think, inappropriate to talk about</p> <p>3 hiding that price increase or spreading it out into some</p> <p>4 other area rather than in the area -- in the service line in</p> <p>5 which the competition was actually harmed.</p> <p>6 Q. So in your view, do health plans have the ability</p> <p>7 to influence patients through financial incentives?</p> <p>8 A. I think they have the ability, but I think that</p> <p>9 some of that is inherent in the enrollees, in the patients</p> <p>10 themselves. There is this testimony, trial testimony by</p> <p>11 Mr. Crouch where he talks about a portion of his enrollees</p> <p>12 being highly sensitive to prices and that they're willing to</p> <p>13 research prices online, and these online tools are being</p> <p>14 provided by Blue Cross. And he says that could represent 10</p> <p>15 percent of his total membership. That's a very significant</p> <p>16 number relative to the critical loss.</p> <p>17 But that's not the end of the story. The health</p> <p>18 plans can take steps to create incentives, to -- for</p> <p>19 individuals to be affected by the price. The best example</p> <p>20 that I've got or one way to illustrate this in this current</p> <p>21 market is to look at the differences between Micron's MHPN</p> <p>22 network, that narrow network that has the lower copay, and</p> <p>23 the Wise PPO network, which was the broader one that has the</p> <p>24 higher copay.</p> <p>25 What happens with these Micron enrollees is when</p>	<p style="text-align: right;">2963</p> <p>1 they become sick, they can choose which network they want to</p> <p>2 be in. They don't have to sign up for the narrow network at</p> <p>3 the beginning of the year and be stuck with that, using that</p> <p>4 for the whole year. Every time they go to the doctor they</p> <p>5 make that decision: Do I go to a narrow network doctor and</p> <p>6 pay 10 percent, or do I go to a Wise PPO network doctor and</p> <p>7 pay a 20 percent copay. And, overwhelmingly, the Micron</p> <p>8 patients choose the MHPN, the narrow network product, and</p> <p>9 they're getting just a 10 percent differential on their</p> <p>10 copay.</p> <p>11 Q. Dr. Argue, if I'm a patient and I've got a copay</p> <p>12 for primary care services, let's say it's, you know, 30,</p> <p>13 \$40, something like that, a 10 percent or 5 percent price</p> <p>14 increase, we're talking about a few dollars, right? I mean,</p> <p>15 is the average patient -- is the average patient going to be</p> <p>16 affected by that?</p> <p>17 A. That's right. If St. Luke's were to increase the</p> <p>18 price by ten bucks, it's not going to have much of an</p> <p>19 impact. If you just carry that through, it would be just a</p> <p>20 dollar and a half or whatever the amount is going to be.</p> <p>21 Q. So then what does a -- does a health plan do</p> <p>22 anything then to help facilitate a patient -- a patient</p> <p>23 change? I mean, if a dollar or two isn't really going to</p> <p>24 make a difference, how does this work?</p> <p>25 A. Well, yeah, absolutely, the health plan does do</p>

<p style="text-align: right;">2964</p> <p>1 something. Now, according to Mr. Crouch's testimony, some</p> <p>2 of that 10 percent is going to be sensitive to that. But I</p> <p>3 do have a demonstrative that illustrates this process of how</p> <p>4 a health plan could initiate changes that would affect how</p> <p>5 the price -- how the price sensitivity of patients arises.</p> <p>6 THE COURT: Mr. Herrick.</p> <p>7 MR. HERRICK: We're going to object to this slide.</p> <p>8 It was, to our knowledge, never -- the analysis that's to be</p> <p>9 presented here was never disclosed previously. This is</p> <p>10 totally new to us, as far as we can tell. We asked counsel</p> <p>11 for St. Luke's to point us to any portion of Dr. Argue's</p> <p>12 reports where this analysis was laid out; they did not.</p> <p>13 MR. STEIN: Your Honor, a couple things. First of</p> <p>14 all, this is purely a demonstrative to illustrate what</p> <p>15 Dr. Argue has been talking about all morning, which is how</p> <p>16 plans change incentives in order to steer patients to one</p> <p>17 provider or another. He's talked about this in the context</p> <p>18 of Micron and other plans.</p> <p>19 This is not -- there's not an exhibit underlying this.</p> <p>20 It's not a -- we're not going to seek to admit this. It's</p> <p>21 simply a way of illustrating his description of how plans</p> <p>22 change payment levels or copayment levels in order to induce</p> <p>23 providers to use one -- you know, one set of providers over</p> <p>24 another.</p> <p>25 THE COURT: Was that issue that is the way that</p>	<p style="text-align: right;">2965</p> <p>1 payors provide incentives to direct patients?</p> <p>2 MR. STEIN: Right, I mean, that is the whole --</p> <p>3 THE COURT: Was that in his report?</p> <p>4 MR. STEIN: Yeah. That is basically a central</p> <p>5 focus of his report and, hence, as you've heard this morning</p> <p>6 and yesterday, a discussion of narrow networks and directed</p> <p>7 benefits. All that relates to how providers -- I'm</p> <p>8 sorry -- how plans change the incentives within a health</p> <p>9 plan in order to direct patients to one set of providers</p> <p>10 over another.</p> <p>11 MR. HERRICK: Your Honor, if I could respond?</p> <p>12 THE COURT: Yes, Mr. Herrick.</p> <p>13 MR. HERRICK: The numbers, the analysis that are</p> <p>14 on this slide that Mr. Stein is about to show the witness</p> <p>15 have never been presented before. We've had no opportunity</p> <p>16 to cross-examine the witness on these numbers or to even</p> <p>17 determine whether the numbers are actually accurate. You</p> <p>18 know, just in basic fairness terms, I don't think this slide</p> <p>19 is at all appropriate.</p> <p>20 MR. STEIN: Well, again, if I could respond,</p> <p>21 Your Honor. This is illustrative. As far as accurate,</p> <p>22 we're not saying this is a -- this comes from a specific</p> <p>23 plan. And as I think Your Honor will see, it's arithmetic;</p> <p>24 in other words --</p> <p>25 THE COURT: I'm going to allow the witness to</p>
<p style="text-align: right;">2966</p> <p>1 testify and use this, and then subject to a motion to strike</p> <p>2 if -- it appears that what you're doing is using this slide</p> <p>3 simply to explain a concept, not necessarily to offer an</p> <p>4 opinion.</p> <p>5 MR. STEIN: That's correct.</p> <p>6 THE COURT: Well, let's see where it goes,</p> <p>7 Mr. Herrick, and then you can renew the objection. If it's</p> <p>8 simply being used to kind of -- similar to something you</p> <p>9 might find in an econ text that would be generally</p> <p>10 understood, I think that's permissible. But if it reflects</p> <p>11 an opinion in this case, then I think the objection is well</p> <p>12 taken, and I'll strike it.</p> <p>13 All right. Proceed.</p> <p>14 BY MR. STEIN:</p> <p>15 Q. So, Dr. Argue, what are we looking at in the first</p> <p>16 column here on slide 65?</p> <p>17 A. The first column in slide 65 is we're supposing we</p> <p>18 have a situation with Saint Al's and St. Luke's -- or let's</p> <p>19 call it just two providers in a network; it doesn't have to</p> <p>20 be Al's and Luke's. And before any price increase, the</p> <p>21 health plan is set up 80 percent allowable, the copay for</p> <p>22 the patient is 20 percent, that's what's going to come out</p> <p>23 of the patient's pocket, and the two providers are the same.</p> <p>24 There is no differential as far as the patient is concerned.</p> <p>25 Q. And then what is indicated in the second column</p>	<p style="text-align: right;">2967</p> <p>1 here?</p> <p>2 A. Now, here is where we're going to put the 5</p> <p>3 percent price increase in. And there are a bunch of steps</p> <p>4 that we have to follow, and that's why I put it in this</p> <p>5 graphic form. So if you could hit the clicker once, there's</p> <p>6 the 5 percent price increase, and that's going to show up as</p> <p>7 \$10 on the top. So rather than the whole charge being \$200,</p> <p>8 the whole charge is \$210.</p> <p>9 And this is what I had just talked about, there</p> <p>10 being a -- if this copay rate stays 20 percent and the</p> <p>11 allowable stays the same, there's a price increase in this</p> <p>12 example of about six and a half dollars. If the plan does</p> <p>13 nothing, if the plan doesn't change anything, the payors --</p> <p>14 the plan is going to pay 5 percent more, and the patient is</p> <p>15 going to pay 5 percent more. Now, 5 percent off a 20</p> <p>16 percent copay is a pretty small portion. That's what's</p> <p>17 going to end up to be just a small amount.</p> <p>18 But the point here is that the plan isn't going to</p> <p>19 do nothing. The plan is getting stuck with an extra 5</p> <p>20 percent, too. Why would it do that if it's got</p> <p>21 alternatives? It would take advantage of the strength that</p> <p>22 it's got in the market by going back to the other</p> <p>23 provider -- in this illustration it's Saint Al's, but it</p> <p>24 doesn't really matter what it is -- going back to the other</p> <p>25 provider and striking a deal, saying let's -- let me make a</p>

<p>2968</p> <p>1 separate tier or a separate network -- let's just think of</p> <p>2 it as a separate tier -- in which you, the provider who</p> <p>3 didn't increase price, are going to be the only provider.</p> <p>4 I'm going to strike a deal with you, and because of that</p> <p>5 you're going to get greater volume. What I'm going to do,</p> <p>6 the plan is going to do, it's going to lower the copay rate</p> <p>7 to, say, 10 percent, and that's going to draw patients in.</p> <p>8 Because patients are now going to be paying less,</p> <p>9 they're going to be inclined to use that. The plan would</p> <p>10 also lower the allowable from 80 percent, in this</p> <p>11 illustration, to 70 percent. The point of lowering the</p> <p>12 allowable is to make the plan as well off. So in this</p> <p>13 example I'm showing, now the plan is paying -- it's paying</p> <p>14 126 on this as compares to the 128 before. The point of</p> <p>15 that was to make the health plan to be comparable. And the</p> <p>16 copay for the patient has fallen substantially for two</p> <p>17 reasons: One is because the allowable has come down, and</p> <p>18 the second is because the copay, which is a percentage of</p> <p>19 the allowable, has also come down.</p> <p>20 Now, what's important here is comparing the higher</p> <p>21 copay for using St. Luke's or a higher copay for using the</p> <p>22 provider that increased its prices, that copay hadn't</p> <p>23 changed, and the price had gone up. And comparing that now</p> <p>24 to this new narrow tier, where everything is lower, the</p> <p>25 copay and the allowable are lower, and you end up with a</p>	<p>2969</p> <p>1 substantial price increase. This is a mechanism by which a</p> <p>2 health plan can influence and sort of pass on this price</p> <p>3 increase to the patient. The health plan is trying to make</p> <p>4 the patient sensitive to a change in prices. And it's</p> <p>5 actually trying to drive -- trying to drive patient volume</p> <p>6 to its narrow tier, to its lower-priced network, and it does</p> <p>7 that by having that lower copay.</p> <p>8 That lower copay, because of these changes, is now</p> <p>9 a substantial difference between the old copay and the new</p> <p>10 copay, but yet the price increase of the provider was still</p> <p>11 just the 5 percent. It's the mechanism that the -- that the</p> <p>12 plan uses to take advantage of patients' willingness or</p> <p>13 responsiveness to the changes in their out-of-pocket costs.</p> <p>14 MR. HERRICK: Just to clarify, Your Honor, if</p> <p>15 Dr. Argue and counsel are not offering this as an example of</p> <p>16 anything accurate about this market in terms of pricing or</p> <p>17 payments that are actually being made, we would withdraw our</p> <p>18 objection.</p> <p>19 THE COURT: And that was my take on the --</p> <p>20 MR. STEIN: Yeah. I guess I wouldn't say</p> <p>21 accurate. I would say it --</p> <p>22 BY MR. STEIN:</p> <p>23 Q. Dr. Argue, this is not -- these dollars are not</p> <p>24 pulled from a specific plan -- a specific plan; is that</p> <p>25 right?</p>
<p>2970</p> <p>1 A. They aren't.</p> <p>2 THE COURT: He is explaining a concept, I think.</p> <p>3 And I think with that understanding, we'll go ahead and</p> <p>4 proceed.</p> <p>5 BY MR. STEIN:</p> <p>6 Q. Is the concept that's reflected here, is this the</p> <p>7 same concept that you've been discussing in the context of</p> <p>8 narrow networks and directed networks and tiered benefits?</p> <p>9 A. Yes. It's all about how the payor influences the</p> <p>10 patient's choice.</p> <p>11 MR. STEIN: Your Honor, we're about to get into a</p> <p>12 tranche of slides that have been designated as AEO by -- it</p> <p>13 may just be Blue Cross, but there may be one or two Regence</p> <p>14 documents here, which would mean, I think, we need to</p> <p>15 probably exclude folks. I don't think I can reasonably do</p> <p>16 them just turning off the monitor.</p> <p>17 THE COURT: All right. We'll have to then direct,</p> <p>18 I guess, anyone who has not been designated as permitted to</p> <p>19 remain because they signed the protective order in this</p> <p>20 matter will need to leave the courtroom.</p> <p>21 *****COURTROOM CLOSED TO THE PUBLIC*****</p> <p>22 BY MR. STEIN:</p> <p>23 Q. Now, Dr. Argue, in the first couple of weeks of</p> <p>24 trial -- actually, probably the first week of trial, we</p> <p>25 heard some testimony from payors about anecdotal examples of</p>	<p>2971</p> <p>1 negotiations they engaged in that I believe the plaintiffs</p> <p>2 are citing as evidence that increased concentration or the</p> <p>3 Saltzer transaction will lead to market power. And I would</p> <p>4 like to give you an opportunity to address some of those.</p> <p>5 The first one I would like to talk about is the</p> <p>6 evidence that when Regence was trying to assemble a PPO,</p> <p>7 they went to Saltzer, and Saltzer was able to resist taking</p> <p>8 a reduction in reimbursement in order to participate in the</p> <p>9 PPO. You're generally familiar with the testimony I'm</p> <p>10 referring to?</p> <p>11 A. Yes.</p> <p>12 Q. How does that testimony fit into your assessment</p> <p>13 of competitive effects?</p> <p>14 A. I think that interpreting that sequence of events</p> <p>15 as reflecting harm to competition is just a</p> <p>16 misinterpretation of what happened. What goes on here is</p> <p>17 that -- and this is largely based on the testimony of</p> <p>18 Ms. Powell -- is that Regence demanded a 5 to 6 percent rate</p> <p>19 reduction from Saltzer in order to join the Regence PPO</p> <p>20 network. Now, the PPO network and the traditional network</p> <p>21 were essentially the same. Saltzer was already in the</p> <p>22 traditional network. So it's sort of turning the managed</p> <p>23 care negotiation on its head to say that Saltzer should</p> <p>24 accept a rate reduction but get no increase in volume in</p> <p>25 exchange for that. And in fact, that's what Saltzer</p>

2972

2973

1 believed, that Regence would shift enrollees out of the
2 traditional product into the PPO product, and that that's
3 what ultimately happened, and so there was no increase in
4 patient volume.

5 And Mr. Clement evidently recognized this
6 reasoning and, ultimately, agreed to keep Saltzer at the
7 traditional rate.

8 Q. Let me just back up for a second and ask more of a
9 threshold question. If -- do I understand correctly that
10 when we talk about market power, at least in the plaintiffs'
11 theory of market power, that essentially what that means is
12 that when the payor sits down with a provider in Nampa who
13 has market power, that it doesn't -- if the provider has
14 market power, then the payor doesn't really have outside
15 options or enough other providers in the market such that it
16 could exclude the one with market power?

17 A. That's a fair representation of what market power
18 means.

19 Q. Okay. So if Saltzer had market power in Nampa,
20 could it have market power as to Regence but not have market
21 power as to Blue Cross?

22 A. It doesn't make sense to have market power only
23 relative to one of the payors and not the other. It's the
24 same change in the structure of the market that's creating
25 the market power in the first place. It's going to apply to

1 Regence. It's going to apply to Blue Cross or anybody else.
2 Q. So what does it tell you that in the negotiations
3 with Regence, Saltzer was able to resist a decrease in
4 reimbursement, but it wasn't able to get better
5 reimbursement terms or an increase in reimbursement from
6 Blue Cross?

7 A. Well, it couldn't be that Saltzer has market power
8 relative to Regence and, therefore, was able to resist this
9 rate increase. When we look at their -- the rates they've
10 received from Blue Cross, and they've been pegged at the
11 statewide rate that Blue Cross gives to providers each time.
12 It -- clearly, Saltzer didn't have market power with regard
13 to Blue Cross. Couldn't raise its rates there. It would be
14 illogical to believe that Saltzer does have market power
15 with Regence, whereas it doesn't with Blue Cross.

16 Q. If Blue Cross and Regence have basically the same
17 providers in their network, could it be that Blue Cross
18 could have more outside options for primary care services in
19 Nampa than Regence?

20 A. It shouldn't be. It should be the same.

21 Q. So another -- just to switch topics, another issue
22 that came up in the plaintiffs' case was Mr. Crouch
23 testified that a substantial number of primary care doctors
24 in Twin Falls were not in the Blue Cross network and that
25 they eventually felt like they had to have those providers

2974

2975

1 in the network because it was -- it was a significant
2 volume, and so they ended up paying more -- "they," Blue
3 Cross, ended up paying more than they wanted to pay to bring
4 those providers in the network. I may be paraphrasing, but
5 you're familiar with that testimony?

6 A. I am.

7 Q. How does that fit into your competitive effects
8 analysis?

9 A. I think, again, this is an example that's poorly
10 suited for suggesting that there are harmful competitive
11 effects likely to occur in the Treasure Valley.

12 Let's just review the events here. First of all,
13 Blue Cross signs up the largest customer in the state, and
14 it does this with only 10 percent of the PCPs in Twin Falls
15 in its PPO product. Now, it had the traditional products,
16 so Blue Cross was serving those patients, those enrollees in
17 Twin Falls. But it was able to get this large customer with
18 only 10 percent of the PCP coverage.

19 For a number of years the Physician Center -- this
20 is the group of PCPs in Twin Valley -- Twin Falls,
21 sorry -- refused to accept the demand by Blue Cross for a 7
22 to 10 percent rate reduction in order to join that PPO
23 network. Again, as was in the case with Saltzer that I just
24 talked about, the PPO network and the traditional network
25 were virtually the same. There was going to be no increase

1 in volume coming to the Physician Center PCPs as a result of
2 the rate reduction and being put into the Blue Cross
3 network, the PPO network.

4 And this went on for several years, for five
5 years. And at some point in there St. Luke's acquired the
6 Physician Center and, subsequently, got into negotiations
7 with Blue Cross and was able to get into the PPO network
8 with a reduction in rates. St. Luke's reduced rates from
9 what -- from the traditional level. Not as far as Blue
10 Cross had requested, but St. Luke's did reduce its rates.
11 Now, there is this term that's used in antitrust
12 periodically about a natural experiment, and the suggestion
13 is that what happened in Magic Valley was a natural
14 experiment. We could look at that and predict what's going
15 to happen in the Treasure Valley. And I think that's an
16 inappropriate comparison, as well, not the least of which is
17 because of the differences in what's happening here.

18 In the Magic Valley we've got -- you can just look
19 at the patient flows, and you see that very few patients
20 from Twin Falls leave to go -- the larger city in the
21 area -- leave to go to Jerome or some of these smaller
22 outlying communities.

23 In contrast, in the Treasure Valley, the question
24 is patients leaving the small community and going into the
25 bigger ones, going into Meridian or into Boise. So

<p style="text-align: right;">2976</p> <p>1 it's flipped around completely, and it may appear on the</p> <p>2 surface to look like a natural experiment, but it's really</p> <p>3 not. It's not comparable at all as far as the alternatives</p> <p>4 available for the patients of the area.</p> <p>5 Q. Dr. Argue, did you also look and study the</p> <p>6 negotiating histories between -- the history of negotiations</p> <p>7 between Blue Cross and St. Luke's in light of plaintiffs'</p> <p>8 bargaining theory to see whether St. Luke's acquisition of</p> <p>9 physicians over time has been borne out in higher prices?</p> <p>10 A. Yes, I did.</p> <p>11 Q. And can you describe what conclusions you reached?</p> <p>12 A. Okay. There are -- the next three slides all kind</p> <p>13 of go together, and I'll explain this first one in a little</p> <p>14 bit more detail. This is a Blue Cross document that shows</p> <p>15 its bargaining sequence with St. Luke's for -- it's in late</p> <p>16 2008 for the 2009 contract. And the shaded -- the yellow</p> <p>17 highlight on the left, in the top and on the right, are the</p> <p>18 back-and-forth of -- that Blue Cross and St. Luke's went</p> <p>19 through, with St. Luke's initially requesting a higher rate</p> <p>20 than Blue Cross wanted, Blue Cross initially demanding a</p> <p>21 lower rate. And you can see they go down through that</p> <p>22 process over the course of a couple of months. And they end</p> <p>23 up, in the middle of December, at a rate, agreed-upon rate</p> <p>24 of 5.6 percent. And so that was for the 2009 contract.</p> <p>25 What's especially interesting in this particular</p>	<p style="text-align: right;">2977</p> <p>1 document is the yellow-shaded area in the left-hand corner,</p> <p>2 which is called -- it's titled the "2010 Negotiating</p> <p>3 Strategy based on prior history." St. Luke's had offered</p> <p>4 a -- or requested a rate increase on this document. And</p> <p>5 below that, Blue Cross says what their desired outcome is.</p> <p>6 5.5 percent is their desired outcome. And they, then,</p> <p>7 conclude that their starting point is going to be 4.3, and</p> <p>8 that's exactly as far below their desired outcome as</p> <p>9 St. Luke's is above the desired outcome. It's indicating</p> <p>10 that they are anticipating a closing of that gap and meeting</p> <p>11 somewhere in the middle.</p> <p>12 This is a document for the 2010 contract</p> <p>13 negotiating history, and it has the same pattern over the</p> <p>14 course of the several weeks and months in late 2009, back</p> <p>15 and forth between Blue Cross and St. Luke's, starting one</p> <p>16 higher than the other. They end up with a final agreed rate</p> <p>17 in December of 2010 of 5 -- just over 5 percent.</p> <p>18 Now, the next document --</p> <p>19 Q. Just for the record, the previous slide -- we were</p> <p>20 looking at slide 69 -- was Trial Exhibit 19, and slide 70,</p> <p>21 which we're looking at, is Trial Exhibit 2583.</p> <p>22 And so now we're turning to slide 71?</p> <p>23 A. Right. In slide 71 there is no document. I don't</p> <p>24 have a page that I can point to. But Mr. Crouch testified</p> <p>25 about the negotiations for the 2013-14 agreement. And it's</p>
<p style="text-align: right;">2978</p> <p>1 the same -- he's talking about the same pattern that we saw</p> <p>2 in those other documents, back-and-forth negotiation over</p> <p>3 rates, St. Luke's proposes 7 percent, and they finally come</p> <p>4 to terms, after some months, of 5 and a quarter percent.</p> <p>5 Now, there are two observations that I think are</p> <p>6 important at this point. The first is that this contract</p> <p>7 negotiation took place after the Saltzer acquisition, or it</p> <p>8 was finalized after the Saltzer acquisition was initially</p> <p>9 given the okay. And if there -- any modeling that Blue</p> <p>10 Cross would have done should have incorporated Saltzer.</p> <p>11 They should have already anticipated what St. Luke's and</p> <p>12 Saltzer's position would have been in their modeling and try</p> <p>13 to -- figuring out what that overall price increase was,</p> <p>14 that lower right-hand corner that Professor Dranove talked</p> <p>15 about, and the total aggregate expenditure should already</p> <p>16 have included the Saltzer transaction in there.</p> <p>17 And we get a price increase here agreed on of 5</p> <p>18 and a quarter percent. That's very similar to the price</p> <p>19 increases in the previous years, anywhere between 5 and 5</p> <p>20 and a half percent. This price increase does not appear, to</p> <p>21 me, to be above competitive or to be reflecting any increase</p> <p>22 as a result of the Saltzer transaction. And the plaintiffs</p> <p>23 had made no attempt to suggest that that 5 and a quarter</p> <p>24 percent increase is above competitive levels.</p> <p>25 Q. In your review of the evidence, did you see</p>	<p style="text-align: right;">2979</p> <p>1 evidence that Blue Cross did, in fact, anticipate the</p> <p>2 Saltzer transaction in the course of negotiations over the</p> <p>3 most current contract?</p> <p>4 A. Yes. These contract documents or contract-related</p> <p>5 documents all talk about the relationship or that -- or the</p> <p>6 anticipation that Blue Cross had as to how -- you know, its</p> <p>7 defenses or how it was going to be dealing with the</p> <p>8 Saltzer -- the provision of services by the Saltzer</p> <p>9 physicians.</p> <p>10 Q. This is slide 72, Trial Exhibits 26, 17, and 2.</p> <p>11 A. Yes.</p> <p>12 Q. Now, Dr. Argue, another -- another thing that the</p> <p>13 plaintiffs have elicited testimony on from Mr. Crouch was a</p> <p>14 set of reports that were -- I think they're referred to as</p> <p>15 the "Hospital Conversion Factor Reports" -- that were cited</p> <p>16 as evidence that over the years St. Luke's Boise and</p> <p>17 Meridian hospitals have been able to increase their</p> <p>18 reimbursement relative to other hospitals. Do you recall</p> <p>19 the documents I'm talking about?</p> <p>20 A. I do.</p> <p>21 Q. And did you have an opportunity to take those</p> <p>22 reports, you know, pull apart the underlying analysis and</p> <p>23 determine whether the -- what Blue Cross was doing was an</p> <p>24 appropriate type of measurement?</p> <p>25 A. Well, we got the reports. They were heavily</p>

<p style="text-align: right;">2980</p> <p>1 redacted. Most of the page was black, but there -- so --</p> <p>2 and I did not have access to the statewide data that would</p> <p>3 have been necessary to replicate the process that -- that</p> <p>4 Blue Cross went through to create these conversion factors</p> <p>5 that they've talked about.</p> <p>6 Q. And this -- what we're looking at on slide 74 is</p> <p>7 obviously just a summary of one column of the reports; is</p> <p>8 that right?</p> <p>9 A. That's right. It's a summary of the -- what they</p> <p>10 call the "simple average" column of the reports.</p> <p>11 Q. And so am I right that if you just look at these</p> <p>12 simple averages over time, it does show that St. Luke's</p> <p>13 Boise/Meridian, that the percentage relative to these other</p> <p>14 hospitals here is increasing over time; is that right?</p> <p>15 A. That's right. It goes from the bottom of this</p> <p>16 particular list in 2010 to third place in 2012.</p> <p>17 Q. And was there other information in those reports,</p> <p>18 recognizing you didn't have the underlying data, that you</p> <p>19 thought was relevant to the conclusion that was reached from</p> <p>20 just looking at the simple average?</p> <p>21 A. Yes. And, of course, I couldn't recalculate these</p> <p>22 simple averages. But they had that, and they had what they</p> <p>23 call a "weighted average" as well included in the conversion</p> <p>24 reports.</p> <p>25 Q. And why did you think it was at all relevant to</p>	<p style="text-align: right;">2981</p> <p>1 look at the weighted average rather than the simple average?</p> <p>2 A. Well, the most important part of this is it was</p> <p>3 the weighted average that Blue Cross used when it went to</p> <p>4 negotiate with St. Luke's. It didn't use the simple</p> <p>5 average. It had -- there's another slide presentation that</p> <p>6 Blue Cross has that includes these numbers that are in the</p> <p>7 weighted average column, not in the simple average column.</p> <p>8 Q. What do you see when you sort the hospitals by the</p> <p>9 weighted average rather than the simple average?</p> <p>10 A. St. Luke's Boise/Meridian stays in exactly the</p> <p>11 same point; it's -- one, two, three, four, five, six --</p> <p>12 sixth in rank throughout all three years.</p> <p>13 Q. Now, turning from Professor Dranove and Blue Cross</p> <p>14 for a minute. There was an analysis that Professor Haas-</p> <p>15 Wilson presented in her testimony where there were some bar</p> <p>16 charts that analyzed 21 CPT codes that purported to show</p> <p>17 Treasure Valley and Saint Al's being a lower -- lower price</p> <p>18 than St. Luke's. Do you recall what I'm referring to?</p> <p>19 A. I do.</p> <p>20 Q. Had you previously considered that analysis?</p> <p>21 A. I reviewed it.</p> <p>22 MR. ETTINGER: Your Honor, we're going to need to</p> <p>23 object to this. This was not in any report. First we saw</p> <p>24 that was when we got these slides yesterday.</p> <p>25 THE COURT: Mr. Stein, if that's true, I'll</p>
<p style="text-align: right;">2982</p> <p>1 sustain the objection.</p> <p>2 MR. STEIN: May I respond?</p> <p>3 THE COURT: Yes. That's why I'm --</p> <p>4 MR. STEIN: I can just start reading from</p> <p>5 paragraph 34 of Dr. Argue's surrebuttal report, the first</p> <p>6 sentence of which is, "Professor Haas-Wilson also attempts</p> <p>7 to compare average prices across the set of services</p> <p>8 comprising only the 21 CPT codes that Treasure Valley</p> <p>9 Hospital provides in common with other hospitals."</p> <p>10 And then he goes on to discuss this analysis. I could</p> <p>11 put it up on the ELMO, but --</p> <p>12 THE COURT: Mr. Ettinger?</p> <p>13 MR. ETTINGER: Which paragraph?</p> <p>14 MR. STEIN: 34 of the surrebuttal report.</p> <p>15 MR. ETTINGER: Your Honor, some of what's in</p> <p>16 the -- in part, Mr. Stein is right; in part, I think my</p> <p>17 objection is apropos. There is a lot of detail, though, on</p> <p>18 this slide that was not revealed in the expert report, in</p> <p>19 terms of quantitative comments, the 6 percent, the 93</p> <p>20 percent. The 21 CPT codes are mentioned, but that's the</p> <p>21 only data that's on this slide that are mentioned in this</p> <p>22 report. The other quantitative arguments --</p> <p>23 THE COURT: The rule does require that the report</p> <p>24 must include not only the opinions to be offered, but also</p> <p>25 the reasons or bases for the opinions and the information</p>	<p style="text-align: right;">2983</p> <p>1 relied upon. Now, obviously, I'm not sure that we want the</p> <p>2 report to be a thousand pages long, but it does need to</p> <p>3 cover those basics.</p> <p>4 Now, Mr. Stein, if --</p> <p>5 MR. STEIN: Yeah. I think, again, this is -- what</p> <p>6 is referred to here is purely arithmetic; in other words,</p> <p>7 Dr. Argue is just reciting what the figures they are relying</p> <p>8 on are and are not. In other words, 21 CPT codes. Again, I</p> <p>9 could read the whole paragraph and then, you know, the court</p> <p>10 could make a determination once Dr. Argue --</p> <p>11 THE COURT: Well, let's go off the report, ask the</p> <p>12 questions that are basically tied to the report, and I won't</p> <p>13 consider this slide to the extent that it's not</p> <p>14 incorporated.</p> <p>15 MR. STEIN: Fair enough.</p> <p>16 THE COURT: All right. So the objection is</p> <p>17 sustained in part.</p> <p>18 So go ahead and proceed.</p> <p>19 BY MR. STEIN:</p> <p>20 Q. Dr. Argue, you did conduct an analysis or review</p> <p>21 this slide that purported to show a -- favorable results for</p> <p>22 Treasure Valley Hospital in the context of looking at 21 CPT</p> <p>23 codes; is that right?</p> <p>24 A. Yes, I did.</p> <p>25 Q. And in your view, is looking at a selection of 21</p>

<p style="text-align: right;">2984</p> <p>1 CPT codes -- and just as a reminder, CPT codes, these are</p> <p>2 the -- these are the hundreds or thousands of procedure</p> <p>3 codes that exist, five-digit codes to describe medical</p> <p>4 services?</p> <p>5 A. That's right.</p> <p>6 Q. Okay. And in your view, is looking at 21 of</p> <p>7 those, pulling those out and looking at those across</p> <p>8 hospitals, an appropriate way to ascertain whether one</p> <p>9 hospital is a, quote, lower cost hospital than another?</p> <p>10 A. No. Twenty-one is far too small a sample of the</p> <p>11 CPT codes that are available to be a representative sample</p> <p>12 and to have any meaningful value for predicting what or</p> <p>13 suggesting what the overall price would be.</p> <p>14 Q. Is picking out 1 or 2 or 21 CPT codes out of</p> <p>15 hundreds or thousands and just comparing those prices, is</p> <p>16 that consistent with the bargaining model that the</p> <p>17 plaintiffs opposed where you're just negotiating over that</p> <p>18 lower right-hand corner?</p> <p>19 A. No, that's certainly not. The bargaining model</p> <p>20 that we've been talking about is an overall price increase,</p> <p>21 over all of the services that the parties would agree to.</p> <p>22 And to look at 21 or 51 zip codes -- I mean, of CPT codes</p> <p>23 isn't really informative about what will happen with that</p> <p>24 overall price increase.</p> <p>25 Remember, I had said that they may distribute</p>	<p style="text-align: right;">2985</p> <p>1 that. Some with inpatient, some with outpatient, there</p> <p>2 could be some that are higher and some that are lower. It</p> <p>3 could be that these 21 are all showing big price increases.</p> <p>4 It could also be that the 21 are showing small price</p> <p>5 increases. It's just not very helpful.</p> <p>6 Q. And were the 21 CPT codes that Professor</p> <p>7 Haas-Wilson selected, were these a substantial -- maybe it's</p> <p>8 the fact that these are actually a really substantial number</p> <p>9 of -- represent a substantial number of the procedures that</p> <p>10 are being done at those hospitals, so, you know, the</p> <p>11 remaining 2,000 codes just don't reflect that much volume.</p> <p>12 Is that what you determined?</p> <p>13 A. Well, without knowing exactly what the volume is</p> <p>14 in the 21 CPT codes, I can say, based on my experience, that</p> <p>15 it would be extraordinary for 21 CPT codes to account for a</p> <p>16 substantial portion of TVH's volume.</p> <p>17 Q. So, Dr. Argue, I'd like to move on and talk about</p> <p>18 the issue of entry and expansion and kind of just reframing</p> <p>19 things. We talked a little bit ago about whether plans have</p> <p>20 the ability to and could try to incentivize patients to</p> <p>21 switch away from Saltzer or St. Luke's providers in Nampa to</p> <p>22 other providers in Nampa. Do you recall that?</p> <p>23 A. Yes.</p> <p>24 Q. Okay. And so we've also heard a lot of testimony</p> <p>25 from plaintiffs' witnesses about whether it's easy or</p>
<p style="text-align: right;">2986</p> <p>1 difficult to recruit new primary care providers into Nampa.</p> <p>2 You're familiar with that testimony?</p> <p>3 A. I am.</p> <p>4 Q. And is recruiting new primary care providers to</p> <p>5 Nampa the only way -- the only way that -- or the only</p> <p>6 question to be asking in considering whether entry or</p> <p>7 expansion could be sufficient to defeat an above-competitive</p> <p>8 price increase?</p> <p>9 A. No. It's relevant to think about -- particularly</p> <p>10 as you're thinking about expansion, it's relevant to think</p> <p>11 about what is the available capacity in the market to begin</p> <p>12 with that would -- may be able to take in additional</p> <p>13 patients. The whole point of entry and the whole point of</p> <p>14 expansion is to be able to draw patients away from the</p> <p>15 providers who are raising their prices. If there's no</p> <p>16 excess capacity or there's no ability to expand or enter,</p> <p>17 then that -- those alternatives aren't going to impose a</p> <p>18 very significant competitive constraint.</p> <p>19 If entry can occur or if expansion is available</p> <p>20 or, in this case, there's excess capacity, that can be used</p> <p>21 to draw patients away from the higher-priced providers.</p> <p>22 Q. So let's assume for the moment that recruiting</p> <p>23 primary care doctors to Nampa is so difficult that it won't</p> <p>24 happen. It just -- no new providers would be recruited to</p> <p>25 the market in the next, you know, several years. Okay?</p>	<p style="text-align: right;">2987</p> <p>1 A. Okay.</p> <p>2 Q. Did you consider whether if that were, in fact,</p> <p>3 true, there would, nevertheless, be sufficient capacity in</p> <p>4 the market, non-St. Luke's-Saltzer capacity, for plans to be</p> <p>5 able to -- or for other providers to be able to take a</p> <p>6 sufficient number of patients from Saltzer-St. Luke's to</p> <p>7 defeat a price increase?</p> <p>8 A. Yes.</p> <p>9 Q. And let's go to that analysis.</p> <p>10 Dr. Argue, for the record, we're on slide 80, which is</p> <p>11 "Capacity Utilization and Excess Capacity by PCPs in Nampa."</p> <p>12 And can you describe -- right now the screen is just showing</p> <p>13 the red line and the bubble at the top. Can you describe</p> <p>14 what's reflected there?</p> <p>15 A. What I'm going to look at with the capacity</p> <p>16 utilization is the extent to which number of providers in</p> <p>17 Nampa have available capacity. In order to do that, I need</p> <p>18 to have some measure of what it might be to have full</p> <p>19 capacity, to suggest when they don't have ability to take</p> <p>20 on. I don't have a specific number that I can go to, to</p> <p>21 Saint Al's or any other provider, but I did look at the</p> <p>22 Saltzer physicians in Nampa and said, let's just take their</p> <p>23 average. Some are going to be higher, some are going to be</p> <p>24 lower, but on average, let's suppose that that represents a</p> <p>25 full -- representation of full capacity for the PCPs in</p>

<p style="text-align: right;">2988</p> <p>1 Nampa. And that's the 1477 visits.</p> <p>2 Q. That would be an annual figure?</p> <p>3 A. Yes.</p> <p>4 Q. And then what did you do next after you calculated</p> <p>5 an average capacity -- or the average number of Saltzer</p> <p>6 visits per year?</p> <p>7</p> <p>8</p> <p>9</p> <p>10</p> <p>11</p> <p>12 REDACTED</p> <p>13</p> <p>14</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19 Q. And just to be clear, when you talk about "excess</p> <p>20 capacity," you're measuring -- am I right that, essentially,</p> <p>21 you're measuring the level of work that the SAMG or Primary</p> <p>22 Health providers are doing on average as compared to the</p> <p>23 level of work, the volume of work that Saltzer doctors are</p> <p>24 doing on average?</p> <p>25 A. I think you put in one too many "on average's" in</p>	<p style="text-align: right;">2989</p> <p>1 there. I'm comparing what the SAMG and Primary Health</p> <p>2 actually did against the -- against the Saltzer average.</p> <p>3 Q. So now on slide 81, can you describe what's</p> <p>4 reflected in the right-hand column here?</p> <p>5</p> <p>6</p> <p>7</p> <p>8</p> <p>9</p> <p>10</p> <p>11 REDACTED</p> <p>12</p> <p>13</p> <p>14</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20 Q. Now, the Mercy Physician Group, this is</p> <p>21 the -- these are the -- currently the St. Luke's doctors who</p> <p>22 are in Nampa?</p> <p>23 A. Yes.</p> <p>24 Q. Is that right? But this transaction involves</p> <p>25 having the Saltzer doctors become part of St. Luke's and</p>
<p style="text-align: right;">2990</p> <p>1 Nampa. So why aren't you looking at the volume of Saltzer's</p> <p>2 procedures or visits, and, instead, why are you just</p> <p>3 focusing on the St. Luke's part of the Nampa PCPs?</p> <p>4 A. Well, from an antitrust standpoint, an economic</p> <p>5 analysis, we're trying to see whether we could restore, if</p> <p>6 you will, the balance, the competitive balance between --</p> <p>7 that payors could take advantage of in the Nampa market</p> <p>8 prior to the transaction. Can we restore that? Is there an</p> <p>9 ability to get that same competitive constraint?</p> <p>10 And the constraint before, the constraint that</p> <p>11 disappears as a result of this transaction is that</p> <p>12 St. Luke's is no longer an alternative to Saltzer. And,</p> <p>13 consequently, if we can restore another provider, either</p> <p>14 through entry or expansion or, in this case, the use of</p> <p>15 excess capacity, that will restore that same level of</p> <p>16 competitive constraints between the larger provider and the</p> <p>17 smaller providers that existed prior to this transaction.</p> <p>18 Q. And so what conclusion do you reach from all this</p> <p>19 data?</p> <p>20 A. Thinking of entry and expansion as an offset or a</p> <p>21 defense, I guess, against any potential competitive harm, as</p> <p>22 you're evaluating these competitive effects, it's clear to</p> <p>23 me that there is sufficient capacity already available in</p> <p>24 Nampa among those existing non-Saltzer/non-St. Luke's PCPs</p> <p>25 to be able to draw off more than as many patients as</p>	<p style="text-align: right;">2991</p> <p>1 St. Luke's drew off in advance and will ensure that there is</p> <p>2 continued competitive constraints available in Nampa.</p> <p>3 Q. So there's enough existing capacity if there were</p> <p>4 to be incentives to switch. But we keep coming back to this</p> <p>5 question, Dr. Argue, would patients switch? Would enough</p> <p>6 patients switch?</p> <p>7 A. That's certainly a fundamental question, and there</p> <p>8 are sources of information that shed some light on that.</p> <p>9 And, first of all, just to reiterate -- I'm sounding a bit</p> <p>10 like a broken record, but the antitrust comparison is with</p> <p>11 the critical loss level of switching, and we're not talking</p> <p>12 about whole-scale switching, but some much more moderate</p> <p>13 amount.</p> <p>14 And we have testimony on that. Mr. Crouch's</p> <p>15 testimony that I referenced before about the 10 percent of</p> <p>16 the BCI insureds are, as he described it, highly price-</p> <p>17 sensitive and willing to go out there and research online</p> <p>18 for lower prices.</p> <p>19 We have shown through Micron that there are</p> <p>20 financial incentives that can prove effective in overcoming</p> <p>21 patients' preferences. If we believe, inherently, that</p> <p>22 patients prefer to have greater choice in a broader network,</p> <p>23 what Micron has shown us is that patients are willing, for a</p> <p>24 difference in copays, to accept a much more limited network,</p> <p>25 overwhelmingly willing to take that narrower network.</p>

<p style="text-align: right;">2992</p> <p>1 And there is some additional information about the</p> <p>2 so-called loyalty of patients to a PCP. Many patients, in</p> <p>3 fact, don't even have a PCP or are unhappy with their PCP.</p> <p>4 And this slide here identifies some surveys from Deloitte</p> <p>5 and from Physician Foundation Survey and Amednews -- these</p> <p>6 are actually all cited in Professor Dranove's report -- that</p> <p>7 shows that the proportion of patients -- sorry -- of</p> <p>8 enrollees who don't have a PCP in the first place, and it's</p> <p>9 15, 20, 25 percent of patients.</p> <p>10 And there was some testimony by -- I think it was</p> <p>11 Mr. Petersen of the significant number of patients who don't</p> <p>12 have a primary care provider. All of those, in those</p> <p>13 surveys at the top, where they don't have a PCP, that's in</p> <p>14 excess of the critical loss. There also are survey results</p> <p>15 about patients willing to switch or not being -- not</p> <p>16 satisfied with the PCPs. These may seem like small numbers</p> <p>17 in the context of viewing a survey result, 10, 15 percent,</p> <p>18 but they're big numbers when compared against critical loss.</p> <p>19 Q. Dr. Argue, I'd like to switch gears now -- we've</p> <p>20 spent a fair amount of time talking about the primary care</p> <p>21 services market -- and turn to the hospital plaintiffs'</p> <p>22 claims of vertical foreclosure.</p> <p>23 And, Your Honor, I think we've still got a little more</p> <p>24 attorneys' eyes only, but if we can get through the first, I</p> <p>25 don't know, seven or eight slides, we should, then, be able</p>	<p style="text-align: right;">2993</p> <p>1 to reopen --</p> <p>2 THE COURT: We're going to take a break in about</p> <p>3 25 minutes, if that's of any assistance.</p> <p>4 MR. STEIN: Okay.</p> <p>5 MS. DUKE: And is it attorneys' eyes only where</p> <p>6 Saint Al's can still stay out at this point?</p> <p>7 MR. STEIN: It's Treasure Valley Hospital.</p> <p>8 MS. DUKE: AEO?</p> <p>9 MR. STEIN: AEO.</p> <p>10 BY MR. STEIN:</p> <p>11 Q. So, Dr. Argue, the hospital plaintiffs, Saint Al's</p> <p>12 and Treasure Valley Hospital, are claiming that they're</p> <p>13 going to be foreclosed in the markets for inpatient and</p> <p>14 certain outpatient services; is that right?</p> <p>15 A. Yes.</p> <p>16 Q. So before we get into the analysis, can you define</p> <p>17 for the court what foreclosure is to an economist and also,</p> <p>18 more relevant, what anticompetitive foreclosure is.</p> <p>19 A. All right. Well, let's start with the generic</p> <p>20 foreclosure. And foreclosure happens all the time when any</p> <p>21 rival is excluded from access to an input. Now, in this</p> <p>22 case the input is the referral or the patient coming to the</p> <p>23 hospital; that's the input that the hospital is looking for.</p> <p>24 But foreclosure is not of concern for competitive</p> <p>25 reasons unless it excludes a -- excludes a competitor from a</p>
<p style="text-align: right;">2994</p> <p>1 sufficient volume of inputs that are available in the -- in</p> <p>2 the relevant market. The exclusion of a competitor from</p> <p>3 a -- of a single source of sales or input is not likely to</p> <p>4 be harmful if there are sufficient other sources of patients</p> <p>5 or other sources of input already available in the market</p> <p>6 for which the competitor can compete.</p> <p>7 Q. So when we talk about foreclosure from a</p> <p>8 sufficient number of referrals, what is the geographic</p> <p>9 market we should be focusing on with respect to referrals</p> <p>10 for inpatient and outpatient services?</p> <p>11 A. For the referrals analysis, we need to be focusing</p> <p>12 on the Ada and Canyon County market; that's the geographic</p> <p>13 area from which the hospitals get these inputs, they get</p> <p>14 these patients. The horizontal overlap, which we've talked</p> <p>15 about up to this point, the focus was on Nampa, but not for</p> <p>16 the vertical case.</p> <p>17 Q. And you've considered the analyses that Professor</p> <p>18 Haas-Wilson did and presented in court a couple of weeks ago</p> <p>19 that she says demonstrate foreclosure?</p> <p>20 A. Yes.</p> <p>21 Q. And what conclusions have you reached based on</p> <p>22 your study of Professor Haas-Wilson's analyses?</p> <p>23 A. Having looked at Professor Haas-Wilson's analysis</p> <p>24 and listened to her testimony, my conclusion is that she</p> <p>25 failed to demonstrate anticompetitive or competitively</p>	<p style="text-align: right;">2995</p> <p>1 significant foreclosure, and I think her referral analysis</p> <p>2 has some methodological flaws and, in some ways, is</p> <p>3 inapplicable. But there is no reason to expect any</p> <p>4 competitive harm to arise from the shifts of referrals</p> <p>5 following the transaction, the Saltzer transaction.</p> <p>6 Q. But doesn't she show that there is going to be --</p> <p>7 there has been or is likely to be a decrease in referrals to</p> <p>8 Treasure Valley Hospital, for example, from Saltzer primary</p> <p>9 care doctors?</p> <p>10 A. She -- she examines that. She looks at that, yes.</p> <p>11 Q. What's the significance of that?</p> <p>12 A. There is not much significance from a competitive</p> <p>13 standpoint as long as there are other sources of referrals</p> <p>14 available to Treasure Valley or to Saint Al's.</p> <p>15 Q. Now, Doctor, are you -- you've had a chance to</p> <p>16 review the most recent financial information that was</p> <p>17 produced by TVH for 2013 that was -- that was discussed in</p> <p>18 the testimony of Nick Genna?</p> <p>19 A. Yes.</p> <p>20 Q. And slide 89 is from one of the demonstratives</p> <p>21 that we used with Mr. Genna and that now is an exhibit to</p> <p>22 the supplemental report you submitted; is that correct?</p> <p>23 A. That's correct.</p> <p>24 Q. Using this exhibit, which shows the cases at</p> <p>25 Treasure Valley Hospital and the Treasure Valley Surgery</p>

<p style="text-align: right;">2996</p> <p>1 Center from 2008 to 2012 -- actually, it looks like it has</p> <p>2 2013, as well -- could you use this to illustrate the</p> <p>3 difference between foreclosure and anticompetitive</p> <p>4 foreclosure?</p> <p>5 A. Sure. There -- let's just focus on the difference</p> <p>6 between the orange part, the top line, and the Saltzer and</p> <p>7 the BOC lines below. The decline in cases by the Saltzer</p> <p>8 surgeons or by BOC might represent generic foreclosure.</p> <p>9 Some volume of those surgeons' patients are going elsewhere.</p> <p>10 But that's not the part you would look at for trying to</p> <p>11 determine what is relevant for competitive analysis.</p> <p>12 For the competitive analysis, you need to look at</p> <p>13 the overall patient volume and the referrals that TVH is</p> <p>14 receiving from all sources in the market. It's not</p> <p>15 foreclosure or competitively harmful foreclosure if TVH</p> <p>16 loses patients from one hand and picks up an offsetting</p> <p>17 number from another source and they end up better off, or at</p> <p>18 least as well off, which is what the top line of this chart</p> <p>19 shows; that in 2009, '10, and '11, and I guess 2012, TVH's</p> <p>20 volume was essentially flat, and by 2013 it had increased</p> <p>21 substantially. This is not the profile of a company that</p> <p>22 has been suffering competitive -- anticompetitive</p> <p>23 foreclosure.</p> <p>24 Q. And what are we looking at on slide 90?</p> <p>25 A. This zooms in on 2012 and '13, and it compares</p>	<p style="text-align: right;">2997</p> <p>1 those last two years. Now, it's only through the first</p> <p>2 eight months of the year because we only had the first eight</p> <p>3 months for 2013, and we compared that to the same period in</p> <p>4 2012. You can see that the volume at TVH and TVSC rises</p> <p>5 substantially in that period, from 3200 to 3900 cases.</p> <p>6 And in those red boxes at the bottom, there is a</p> <p>7 part of the explanation for what's going on. And the first</p> <p>8 is that TVH's volume falls from 1189 to 563. But look what</p> <p>9 happens to TVSC's volume. It goes from 22 to 542, leaving</p> <p>10 the overall volume pretty much the same for the Saltzer</p> <p>11 surgeon. But even if that -- even that decline is more than</p> <p>12 offset by the increase in the blue portion of that bar in</p> <p>13 2013.</p> <p>14 Q. And when you're considering whether a reduction in</p> <p>15 referrals from Saltzer is likely to constrain Treasure</p> <p>16 Valley Hospital as a competitor in this market, is it</p> <p>17 appropriate to also look at Treasure Valley Hospital's</p> <p>18 overall financial situation?</p> <p>19 A. Yes.</p> <p>20 Q. And did you do that?</p> <p>21 A. Yes, I did.</p> <p>22 Q. And is that reflected in Exhibit 91?</p> <p>23 A. Yes, it is. Exhibit 91 shows, essentially,</p> <p>24 Treasure Valley's profitability and their net revenue per</p> <p>25 case. And they both show the net revenue per case, of</p>
<p style="text-align: right;">2998</p> <p>1 course, is rising pretty dramatically during this period,</p> <p>2 but even the profitability is on an upward trend throughout</p> <p>3 this time. And Treasure Valley, an investor might look at</p> <p>4 that and say, "That looks pretty good." And, in fact,</p> <p>5 Treasure Valley was able to generate some additional</p> <p>6 investors in -- I believe in 2013.</p> <p>7 Q. And so what conclusion, based on your study, have</p> <p>8 you reached about whether the Saltzer transaction is likely</p> <p>9 to result in anticompetitive foreclosure to Treasure Valley</p> <p>10 Hospital?</p> <p>11 A. It's highly unlikely.</p> <p>12 MR. STEIN: Your Honor, at this point we could</p> <p>13 reopen the courtroom.</p> <p>14 THE COURT: All right.</p> <p>15 MR. STEIN: Actually, at this point we could</p> <p>16 reopen the courtroom.</p> <p>17 *****COURTROOM OPEN TO THE PUBLIC*****</p> <p>18 BY MR. STEIN:</p> <p>19 Q. So, Dr. Argue, having talked about Treasure Valley</p> <p>20 Hospital, I want to turn now to the claims made by Saint</p> <p>21 Alphonsus. And you've seen this demonstrative before, this</p> <p>22 was -- this was something that Professor Haas-Wilson used.</p> <p>23 It was kind of a centerpiece of her testimony. It was</p> <p>24 reported in the newspaper. It was her analysis that</p> <p>25 purports to show that when Saint Alphonsus -- I'm</p>	<p style="text-align: right;">2999</p> <p>1 sorry -- when St. Luke's acquires a specialty practice, that</p> <p>2 there is a dramatic, she called it "shifting of admissions"</p> <p>3 from Saint Alphonsus to St. Luke's. Do you recall this?</p> <p>4 A. I do.</p> <p>5 Q. And did you do your own analysis and look under</p> <p>6 the hood, so to speak, to see whether what Professor Haas-</p> <p>7 Wilson is inferring from these numbers really supports</p> <p>8 allegations of foreclosure?</p> <p>9 A. Yes, I looked at that.</p> <p>10 Q. So there are, what, five groups that Professor</p> <p>11 Haas-Wilson looked at; is that right?</p> <p>12 A. That's correct.</p> <p>13 Q. Are any of these primary care groups like Saltzer?</p> <p>14 A. No. These are all single-specialty specialty</p> <p>15 groups.</p> <p>16 Q. Okay. And one of the five groups, Intermountain</p> <p>17 Orthopaedics, in her own analysis, doesn't really show any</p> <p>18 change in admissions to Saint Al's before and after?</p> <p>19 A. That's correct.</p> <p>20 Q. Is that right?</p> <p>21 A. Yes.</p> <p>22 Q. So let's talk about some of the other groups that</p> <p>23 are on here. Idaho Cardiothoracic and Vascular Associates</p> <p>24 or CVA: Did you do any analysis to determine whether the</p> <p>25 acquisition of CVA by St. Luke's, in fact, resulted in</p>

<p style="text-align: right;">3000</p> <p>1 anticompetitive foreclosure as distinct from just a decrease 2 in admissions to Saint Al's by the surgeons who affiliated 3 with St. Luke's? 4 A. I did. I looked at the testimony and some related 5 documents, in this case for Dr. Huerd, and did the same 6 thing for each of the others, as well. And I also did some 7 data analysis. 8 Q. And what did the evidence show? 9 A. Well, with regard to Dr. Huerd, he explains that 10 his volume went down from two or three or three or four 11 patients a week to three or four cases per month, and that 12 his elective cases -- this is after his practice was 13 acquired by St. Luke's -- his elective cases went away. And 14 he said the only entity that lost volume in it was me. His 15 understanding was that Saint Al's total volume had actually 16 gone up, was higher than the normal average after CVA was 17 acquired by St. Luke's. 18 Q. Now, Professor Haas-Wilson's exhibit, it doesn't 19 show what happened to total volumes at Saint Alphonsus 20 following these acquisitions, does it? 21 A. No, it doesn't. It's just showing this 22 proportion, these shares here. 23 Q. Is total volume something that's important to know 24 in order to reach a conclusion about whether an acquisition 25 or series of acquisitions resulted in anticompetitive</p>	<p style="text-align: right;">3001</p> <p>1 foreclosure? 2 A. Certainly. Just like I explained with the TVH 3 data, we need to be looking at the total volume, the whole 4 picture here, not just some portion that represents a subset 5 that may have been fully offset by somebody else. 6 Q. And so what does the evidence that you reviewed 7 show happened to actual -- the overall level of 8 cardiothoracic and vascular surgeries at Saint Al's after 9 the CVA practice was acquired? 10 A. Well, there was some deposition testimony by 11 Ms. Jeffcoat who confirmed that the -- confirmed what 12 Dr. Huerd had testified to, that she didn't know the exact 13 numbers, but she believed that their cardiovascular surgical 14 volume was about even; it had stayed the same and had not, 15 in fact, declined. 16 Q. And so if the volumes of cardiothoracic and 17 vascular surgeries at Saint Al's remained the same after the 18 CVA practice was acquired, because Saint Al's went out and 19 recruited some new surgeons and got referrals from other 20 sources, is that in any respect anticompetitive foreclosure? 21 A. No. There is no anticompetitive foreclosure in 22 that sequence. 23 Q. So let's talk about another one of the groups that 24 was the subject of Dr. Haas-Wilson's analysis, Idaho 25 Pulmonary Associates. And am I correct that you've reviewed</p>
<p style="text-align: right;">3002</p> <p>1 the testimony of Dr. Souza, who testified last week at 2 trial, who is affiliated with that group? 3 A. Yes, I have. 4 Q. What did you take away from Dr. Souza's testimony 5 as it relates to this issue of whether Saint Al's was 6 anticompetitively foreclosed as a result of St. Luke's 7 affiliation with Idaho Pulmonary Associates? 8 A. Well, one initial important observation is that 9 Idaho Pulmonary Associates split. Some of the physicians 10 stayed with Saint Al's, and some of them were acquired by 11 St. Luke's, so there is already some -- there's already a 12 crack in the argument about the anticompetitive foreclosure. 13 But Dr. Souza goes on and testifies he doesn't get referrals 14 from Saint Al's anymore. And this is part of the data 15 analysis that I've done, as well. 16 Q. So if when Idaho Pulmonary Associates split, some 17 doctors went to St. Luke's and some went to Saint Al's and 18 the ones who went to St. Luke's are no longer practicing at 19 Saint Al's, can you tell from -- first of all, is that 20 what's reflected on Professor Haas-Wilson's slide? 21 A. That -- that she's looking at a before and after, 22 and that's what Dr. Souza describes is the before-and-after 23 situation, where the group split after the acquisition of 24 IPA. 25 Q. Does Professor Haas-Wilson show what happened to</p>	<p style="text-align: right;">3003</p> <p>1 the volumes of work done at Saint Al's by the Idaho 2 Pulmonary Associates doctors who stopped working at 3 St. Luke's and started working exclusivity at Saint Al's? 4 A. No. For all we know, that went up substantially. 5 I don't know one way or the other, but she does not consider 6 that at all. 7 Q. Would you have to know that in order to reach any 8 reliable conclusions about whether there has been 9 foreclosure? 10 A. You'd have to know that, at a minimum. You also 11 have to know what other pulmonary referrals are brought to 12 Saint Al's by other physicians. 13 Q. Okay. What about Idaho Cardiology Associates? 14 That's another one of the groups on Professor Haas-Wilson's 15 exhibit; is that right? 16 A. Yes, it is. 17 Q. And did you review the trial testimony of 18 Dr. Marshall Priest? 19 A. Yes, I did. 20 Q. And how does Dr. Priest's testimony affect your 21 understanding of Idaho Cardiology Associates? 22 A. A lot of similarities in the situation for ICA, 23 Idaho Cardiology, as there were for Idaho Pulmonary 24 Associates. Some of the ICA physicians moved to St. Luke's, 25 others went on to -- or remained at Saint Al's. And</p>

3004

3005

1 Saint Al's has actually been very successful in recruiting
2 new cardiologists and has grown that practice substantially.
3 Dr. Priest's testimony was that he believed that
4 the physicians who remained at Saint Al's were supported by
5 the members of the Saint Al's physician practices and that
6 has resulted in a reduction in referrals by him to
7 Saint Al's.

8 **Q.** So in your view, what conclusions can be drawn
9 from Professor Haas-Wilson's analysis showing that when
10 certain physicians affiliated with St. Luke's the volume of
11 their admissions at Saint Al's went down?

12 **A.** No conclusions.

13 **Q.** So did you go further and do any analysis of your
14 own in order to look at the question of whether there is
15 actually any anticompetitive foreclosure that has resulted
16 from prior acquisitions by St. Luke's?

17 **A.** Yes. I did some data analysis on that subject.

18 **Q.** Can you describe for the court generally the
19 methodology that you applied in doing the studies that we're
20 going to talk about?

21 **A.** Sure. The -- we're back with the patient origin
22 data again, but now rather than working with zip codes,
23 we're working with the identity of the physicians and trying
24 to understand referral patterns and admissions and so forth.
25 And what I'm trying to do is to compare a period of time

1 before a group was acquired to a period of time after the
2 group was acquired and see what kind of
3 substantial -- whether there is a substantial difference
4 between the two.

5 Now, with this data we can't tell exactly what a
6 referral is, but we can see the patterns of physicians that
7 each individual patient uses and then their admission to the
8 hospital or referral or use of a specialist. So what I've
9 done to make this data workable is to attribute patients to
10 specific physicians based on the services provided by that
11 physician in the previous eight-week period.

12 So that's saying we go into the data, and we look
13 under doctor A and find all the patients that he saw in the
14 previous eight weeks prior to the acquisition in this time
15 period -- or -- I'm sorry -- prior to the patient's
16 admission, so over this period we're going to say an
17 admission or referred to a specialist, let's back up from
18 that time period and try to see who were the last patients,
19 the last doctors they saw, and we'll kind of attribute that
20 patient to that physician.

21 Then having done that, we examine a 12-month
22 period before the acquisition and compare that to a 12-month
23 period after the acquisition. But I'm going to slice out
24 six months in the middle, take three months right before the
25 acquisition and three months right after and just ignore

3006

3007

1 those. In the event that there is somebody who made a
2 referral, went before he was acquired and didn't get
3 actually admitted until after the acquisition, then it will
4 just confound things to have that. And I don't really care
5 about those few months. I've got plenty of data to look at
6 in the two 12-month intervals.

7 And I also looked at -- I'd mentioned this
8 eight-week period to try to attribute a patient to a
9 physician -- I looked at different periods. I looked at a
10 3-week period or I looked at a 27- or a 29-week period. All
11 of the results come out the same. All of my conclusions are
12 robust to the differences in those attribution periods, so I
13 settled on eight weeks.

14 **Q.** What we're talking about here when we're talking
15 about data, Dr. Argue, is this is data that you got from the
16 payors; is that right?

17 **A.** Yes. It's the Blue Cross and the Regence data.

18 **Q.** That data doesn't include a field or information
19 that would allow you to say, definitively, when this patient
20 was admitted to the hospital, they were referred to the
21 hospital by Dr. X; is that right?

22 **A.** No. We don't know that, which is why I go through
23 that process of trying to attribute a patient to a specific
24 physician based on previous visits to that physician.

25 **Q.** So, Dr. Argue, let's talk about the first analysis

1 that you did. Can you describe what's reflected on slide
2 99. For the record, this is titled, "St. Luke's PCPs *Have*
3 *Not Shifted* Inpatient Admissions Away from Saint Al's
4 Hospitals."

5 **A.** That's the conclusion from that analysis, that
6 those PCPs simply haven't shifted their inpatient admissions
7 away. These are the St. Luke's PCPs. And you can see at
8 the -- in the text at the top of the slide it talks about
9 the number of referrals -- or the number of admissions of
10 patients from the St. Luke's PCP practices before the
11 acquisition and after the acquisition. That -- and it
12 actually grew, 3.2 percent. And that's for all of the
13 practices, all of the PCP practices that St. Luke's
14 acquired.

15 **Q.** I'm sorry. Let me just stop you there --

16 **A.** Yeah.

17 **Q.** -- to make sure we understand. So this is -- when
18 it says "190" and "196," those are the totals of admissions
19 to Saint Al's hospitals in the before and after period by
20 the St. Luke's affiliated primary care groups that you've
21 identified here?

22 **A.** That's right.

23 **Q.** Okay. I'm sorry. Continue.

24 **A.** Okay. And then I broke down some detail. Now,
25 some of these practices are very small, but -- so I took the

<p style="text-align: right;">3008</p> <p>1 five, five large practices here, and just looked at their</p> <p>2 patterns to see what kind of changes were happening in the</p> <p>3 referrals to -- or the admissions of these PCPs at</p> <p>4 Saint Al's before and after their acquisition. Mountain</p> <p>5 View went up substantially, up 47 percent. Capital City was</p> <p>6 up 13. Idaho Family Physicians down a little. Mercy</p> <p>7 Physician Group was down 12 percent.</p> <p>8 That I don't think tells the whole story. What</p> <p>9 was happening with Mercy Physician Group -- and, obviously,</p> <p>10 this is an important one for our analysis because it's in</p> <p>11 Nampa -- was that Mercy Physician Group's overall practice</p> <p>12 was declining, and the share of its physicians -- I'm</p> <p>13 sorry -- the share of its patients who were admitted to a</p> <p>14 Saint Al's facility actually didn't change. It was 63</p> <p>15 percent before, 64 percent after. So there was a -- there</p> <p>16 was a 12 percent decline, we can see that, but it's part of</p> <p>17 the overall problem that Mercy Physician Group was having in</p> <p>18 a decline in their patient population, not a change in their</p> <p>19 admission patterns to Saint Al's hospital.</p> <p>20 Q. And the practices that we're looking at, the first</p> <p>21 four are in Boise, and Mercy is the -- are the St. Luke's</p> <p>22 doctors in Nampa?</p> <p>23 A. Yes.</p> <p>24 Q. Before we move on, Dr. Argue, I want to just go</p> <p>25 back to an issue relating to the methodology quickly. So</p>	<p style="text-align: right;">3009</p> <p>1 you're not able to identify from the data that a primary</p> <p>2 care doctor is the one who, at least figuratively, handed</p> <p>3 the referral slip to the patient; is that right?</p> <p>4 A. Right.</p> <p>5 Q. But you've heard testimony from plaintiffs'</p> <p>6 witnesses that the primary care doctor has a significant</p> <p>7 role in determining who the specialists are and where the</p> <p>8 patient is admitted; is that right?</p> <p>9 A. I've heard that testimony.</p> <p>10 Q. So how does that -- how does that -- that position</p> <p>11 by the plaintiffs or that view affect the way you do your</p> <p>12 analysis?</p> <p>13 A. I think it's important then to look at referrals</p> <p>14 by the PCP to the specialists and to see whether there has</p> <p>15 been any impact as a result of that. And I'm talking about</p> <p>16 referrals from Saint Al's PCPs and to see whether there has</p> <p>17 been any change in that that may be of significance.</p> <p>18 Q. Is there -- do these analyses that you're doing,</p> <p>19 in a way, do they assume that, in fact, the primary care</p> <p>20 physician does play a significant role in where the patient</p> <p>21 is admitted?</p> <p>22 A. I don't -- can you just repeat that question.</p> <p>23 Q. Yeah. Is one of the reasons you feel comfortable</p> <p>24 inferring a link between the primary care physician visit</p> <p>25 and an admission to the hospital because of, as plaintiffs</p>
<p style="text-align: right;">3010</p> <p>1 have articulated, the primary care doctors can play a</p> <p>2 significant role in determining where patients get admitted?</p> <p>3 A. Yes.</p> <p>4 Q. So what are we looking at on slide 100?</p> <p>5 A. This slide shows that, as the title indicates,</p> <p>6 Saint Al's PCPs actually steer referrals away from the</p> <p>7 St. Luke's acquired specialists. They are making,</p> <p>8 apparently, conscious decisions to change their referral</p> <p>9 patterns. Again, we can focus at the text at the top of the</p> <p>10 slide, showing the total referrals from SAMG PCPs to all of</p> <p>11 the acquired specialist practices, and that --</p> <p>12 Q. "SAMG PCPs" -- I'm sorry to interrupt -- but</p> <p>13 that's the Saint Alphonsus-affiliated primary care doctors?</p> <p>14 A. Yes. It shows that prior to the acquisition we're</p> <p>15 tracking 2300-and-something referrals, and afterwards it</p> <p>16 falls to 1700. That's an overall decline of 27 percent.</p> <p>17 That's a very -- in my view, a very substantial shift in the</p> <p>18 Saint Al's PCPs referral practices or patterns.</p> <p>19 And I've shown it now for six or seven groups down</p> <p>20 below. And some of these are very dramatic changes: IPA</p> <p>21 down 60 percent, Boise Orthopedic Center down 41 percent,</p> <p>22 CVA down 62 percent, Boise Surgical Group down 67 percent,</p> <p>23 and the others on there, as well. It was a very dramatic</p> <p>24 change in the referral patterns of the SAMG PCPs to the</p> <p>25 St. Luke's acquired specialists.</p>	<p style="text-align: right;">3011</p> <p>1 Q. And what's the significance of this information in</p> <p>2 the overall foreclosure analysis?</p> <p>3 A. Well, this goes back to -- this is the data</p> <p>4 analysis that I was talking about when we were talking</p> <p>5 before about IPA and CVA. These -- Dr. Huerd, say, for</p> <p>6 example, of CVA, testified that he wasn't getting referrals</p> <p>7 from the SAMG PCPs anymore. This data is showing</p> <p>8 that's exactly right and -- or was getting far fewer</p> <p>9 referrals. And that means that some of the decline in</p> <p>10 patient volume by those specialists at Saint Al's is</p> <p>11 self-inflicted. It's caused by changes in Saint Al's</p> <p>12 physicians' own referral patterns. Now, those patients are</p> <p>13 not suddenly not getting sick. What's happening is they are</p> <p>14 being referred to another specialist. They need cardiac</p> <p>15 surgery, Saint Al's wants them to stay in the system, they</p> <p>16 refer them to a Saint Al's cardiovascular surgeon instead.</p> <p>17 Q. Now, we know, Dr. Argue, that, you know, sometimes</p> <p>18 the primary care doctor doesn't send a patient right to the</p> <p>19 hospital or to the emergency room. Maybe they make a</p> <p>20 referral to a specialist who is then going to do a procedure</p> <p>21 at a hospital; right?</p> <p>22 A. That's right.</p> <p>23 Q. So did you also look to see what happens to</p> <p>24 referrals by primary care doctors affiliated with St. Luke's</p> <p>25 to specialists before and after an acquisition?</p>

<p style="text-align: right;">3012</p> <p>1 A. Yes, I did.</p> <p>2 Q. Is that the summary of your study on slide 101?</p> <p>3 A. Yes, it is. And what I found is that the</p> <p>4 St. Luke's PCP referrals going to Saint Al's specialists</p> <p>5 remained virtually unchanged as to the share. There was a</p> <p>6 decline in the number of referrals, but the shares didn't</p> <p>7 change at all. For example, overall, if we look at all of</p> <p>8 the specialists, the share of St. Luke's PCPs referrals</p> <p>9 going to Saint Al's specialists changed from 5.2 percent of</p> <p>10 their total referrals to 5 percent of their total referrals.</p> <p>11 It was not a substantial decline.</p> <p>12 If we look at Mercy Physician Group, for example,</p> <p>13 you can see that Mercy Physician Group's share of referrals</p> <p>14 going to Saint Al's specialists actually rose. It rose</p> <p>15 during this period. Capital City Family Medicine also was</p> <p>16 sending a greater proportion of its referrals to Saint Al's</p> <p>17 specialists. Some of the other practices showed declined,</p> <p>18 but overall there was very little change in what the</p> <p>19 St. Luke's PCPs were doing as a share of their practice.</p> <p>20 That controls for any difference in the size of their</p> <p>21 practice over time.</p> <p>22 THE COURT: Dr. Argue, let me just ask a quick</p> <p>23 question. We had a hearing much earlier in the year at</p> <p>24 which Saint Al's and Treasure Valley sought to enjoin the</p> <p>25 merger, and I indicated a concern that we maintain the</p>	<p style="text-align: right;">3013</p> <p>1 status quo and made -- and I think it was probably perceived</p> <p>2 that a loss of referrals might be perceived by the court as</p> <p>3 an indication that indeed some of the concerns expressed by</p> <p>4 Saint Al's would, in fact, come true, which raises the</p> <p>5 potential that perhaps there was some kind of reverse</p> <p>6 steering, if you will, concern about this litigation and the</p> <p>7 outcome of the litigation which might have affected that.</p> <p>8 And I raise that because it -- much of the testimony is</p> <p>9 that there is a natural propensity to refer to doctors that</p> <p>10 you're affiliated with and work with in your practice group.</p> <p>11 And that does not seem to be borne out by these -- this last</p> <p>12 slide and these numbers.</p> <p>13 Is there any way to measure the extent to which there</p> <p>14 may have been some, I guess, secondary gain or alternative</p> <p>15 motivation that might have affected decision-making in terms</p> <p>16 of referral patterns? Or did you take that into account?</p> <p>17 THE WITNESS: If I can -- I think I --</p> <p>18 THE COURT: I probably wasn't being particularly</p> <p>19 clear.</p> <p>20 THE WITNESS: I think I'm hearing two questions,</p> <p>21 but I'm not sure.</p> <p>22 THE COURT: They are two questions, but --</p> <p>23 THE WITNESS: May I take a stab at one of them</p> <p>24 that I think is helpful?</p> <p>25 THE COURT: Yes. Both, actually.</p>
<p style="text-align: right;">3014</p> <p>1 THE WITNESS: Okay.</p> <p>2 THE COURT: We're going to take a break here in</p> <p>3 just a minute. Go ahead and answer.</p> <p>4 THE WITNESS: One thing that you'll notice on</p> <p>5 these charts is that there are no dates on the chart. It's</p> <p>6 just a pre period and a post period. And the reason for</p> <p>7 that is because some of these acquisitions occurred years</p> <p>8 ago, and some of them occurred more recently. All I'm</p> <p>9 looking at is the 12-month or 15-month window on either side</p> <p>10 of the acquisitions. None of those are subsequent to this</p> <p>11 transaction.</p> <p>12 THE COURT: Okay. I understand. I misunderstood</p> <p>13 then. This chart actually shows pre -- in each -- these are</p> <p>14 five different acquisitions --</p> <p>15 THE WITNESS: That's right.</p> <p>16 THE COURT: -- not necessarily --</p> <p>17 THE WITNESS: That's right.</p> <p>18 THE COURT: Okay. I misunderstood the slide, and</p> <p>19 then my question doesn't make any sense. I apologize. I</p> <p>20 had thought this was a comparison of pre and post</p> <p>21 acquisition focusing on the St. -- or the --</p> <p>22 THE WITNESS: The Saltzer.</p> <p>23 THE COURT: -- the Saltzer acquisition. And I</p> <p>24 just missed that piece.</p> <p>25 THE WITNESS: I'm glad you asked the question</p>	<p style="text-align: right;">3015</p> <p>1 because that's -- that wasn't clear in my description, and I</p> <p>2 apologize for that. But this is all related around the</p> <p>3 acquisition of the specialty group or of the primary care</p> <p>4 physician group.</p> <p>5 THE COURT: That's very helpful. Thank you.</p> <p>6 THE WITNESS: Okay.</p> <p>7 THE COURT: All right.</p> <p>8 BY MR. STEIN:</p> <p>9 Q. Dr. Argue, so, for example, for the acquisition of</p> <p>10 Mountain View, which was -- I can't remember if it was fall</p> <p>11 of 2007 or 2008 -- am I right that what we're looking at</p> <p>12 there for the before and after would be you cut out three</p> <p>13 months on either side of the acquisition and then would have</p> <p>14 gone back 12 months? So the before period here would</p> <p>15 actually be 2006, 2007?</p> <p>16 A. That's right.</p> <p>17 Q. And the after period would be some time period in</p> <p>18 2007, 2008?</p> <p>19 A. Yeah, whatever it is. Something along those</p> <p>20 lines.</p> <p>21 THE COURT: Counsel, we're a little past where we</p> <p>22 take the morning break. Is this --</p> <p>23 MR. STEIN: Yes, Your Honor.</p> <p>24 THE COURT: You can go on for a few more minutes</p> <p>25 if you need to to --</p>

<p style="text-align: right;">3016</p> <p>1 MR. STEIN: I think now is a good time.</p> <p>2 THE COURT: We'll take a 15-minute recess. We'll</p> <p>3 be in recess.</p> <p>4 (Recess.)</p> <p>5 THE COURT: Dr. Argue, I'll remind you you are</p> <p>6 still under oath.</p> <p>7 Mr. Stein, you may resume your direct -- your direct</p> <p>8 examination of the witness.</p> <p>9 MR. STEIN: Thank you.</p> <p>10 BY MR. STEIN:</p> <p>11 Q. Dr. Argue, I just want to go back to one thing we</p> <p>12 talked about earlier this morning, which was I think in the</p> <p>13 context of talking about Professor Dranove's diversion</p> <p>14 analysis and this idea that the Saltzer doctors and the</p> <p>15 St. Luke's doctors are more popular, I guess, than the SAMG</p> <p>16 doctors, the alternatives.</p> <p>17 So -- and I realize you've testified that actually you</p> <p>18 think it's -- between the St. Luke's and the SAMG doctors,</p> <p>19 there is not that much difference, according to Professor</p> <p>20 Dranove's analysis. But let's assume he is right and that</p> <p>21 Saltzer and the St. Luke's doctors are the, quote/unquote,</p> <p>22 most popular doctors in Nampa.</p> <p>23 If there -- if they were only contracting through</p> <p>24 St. Luke's -- you know, let's say they are not in Blue Cross</p> <p>25 or they're not in other networks -- isn't that going to make</p>	<p style="text-align: right;">3017</p> <p>1 the St. Luke's network look more attractive to some number</p> <p>2 of patients -- more attractive than competitors?</p> <p>3 A. It probably will. That's how health plans</p> <p>4 compete. And by constructing networks that are attractive</p> <p>5 to their enrollees or their prospective enrollees, it's</p> <p>6 important for them to be able to build a product that they</p> <p>7 can sell to the enrollees. But it's -- in selling something</p> <p>8 you don't -- you can change prices, you can change other</p> <p>9 features.</p> <p>10 So a narrow-network product like I had talked</p> <p>11 about before -- which might be, say, Saint Al's Health</p> <p>12 Alliance without Saltzer or IPN without Saltzer -- may sell</p> <p>13 at a different price. And, you know, customers -- patients</p> <p>14 throughout the area and employers are different. They have</p> <p>15 got different preferences for a broad network that might be</p> <p>16 a higher price or a narrow network that might be lower.</p> <p>17 It's not likely that everybody has got the same preferences.</p> <p>18 So the plans are trying to appeal to a spectrum of</p> <p>19 customers throughout the Treasure Valley and should be able</p> <p>20 to construct different types of networks that would be able</p> <p>21 to attract patients.</p> <p>22 Q. If plans or networks that are competing against</p> <p>23 St. Luke's or a combined St. Luke's and Saltzer have outside</p> <p>24 options for members of the networks, does the fact that the</p> <p>25 St. Luke's doctors or Saltzer doctors are viewed more</p>
<p style="text-align: right;">3018</p> <p>1 favorably, is that relevant for the antitrust analysis?</p> <p>2 A. As long as there are outside options, acceptable</p> <p>3 alternatives for health plans and constructing networks, you</p> <p>4 should be able to get competitive prices.</p> <p>5 Q. So, Dr. Argue, let's turn to the last section of</p> <p>6 your analysis, which relates to procompetitive benefits.</p> <p>7 Can you describe for the court what conclusions you've</p> <p>8 reached with regard to procompetitive benefits.</p> <p>9 A. I have reviewed a lot of information related to</p> <p>10 the procompetitive benefits, and I think that the Saltzer</p> <p>11 transaction will improve the ability of St. Luke's and</p> <p>12 Saltzer to take on risk contracting in particular. And risk</p> <p>13 contracting is a key part of the procompetitive benefits</p> <p>14 coming from this.</p> <p>15 And while St. Luke's has some ability absent</p> <p>16 Saltzer to take on risk contracting, it's tremendously</p> <p>17 important for Saltzer and their patients to be able to take</p> <p>18 advantage of these benefits, many of which they may not be</p> <p>19 able to capture at all or certainly not as quickly. Having</p> <p>20 a hospital partner is a key part of the alignment of</p> <p>21 financial incentives that -- that is part of this</p> <p>22 value-based care that I talked about yesterday.</p> <p>23 There is the high cost of implementing IT systems.</p> <p>24 There is the benefits of scale for clinical analyses and the</p> <p>25 benefits of scale in spreading these fixed costs. There is</p>	<p style="text-align: right;">3019</p> <p>1 the support for transitioning from fee-for-service care to</p> <p>2 value-based care.</p> <p>3 These are all things that I mentioned yesterday.</p> <p>4 And Saltzer, in particular, would be hard pressed to take</p> <p>5 advantage of those without the resources and the partnership</p> <p>6 with St. Luke's.</p> <p>7 Q. Were there any other procompetitive benefits of</p> <p>8 the St. Luke's-Saltzer transaction that you identified?</p> <p>9 A. I think there are some. There is clearly some in</p> <p>10 the improved access to care for Medicaid and uninsured</p> <p>11 patients in that St. Luke's accepts all patients, and that</p> <p>12 enhances the access points for those individuals.</p> <p>13 We have talked about the coordination of care, the</p> <p>14 flow of information and communication with the Epic IT</p> <p>15 system, the coordination that that helps enhance between the</p> <p>16 PCPs and specialists. The change in financial incentives</p> <p>17 can have an impact on utilization.</p> <p>18 And there really are -- there are two key points</p> <p>19 that are at the bottom of this slide that I think are worth</p> <p>20 kind of focusing on for a minute. One is the increased</p> <p>21 competition in the insurance market, and the other is</p> <p>22 spurring competition from Saint Al's, both of which are</p> <p>23 enhanced by this transaction.</p> <p>24 Q. So, Dr. Argue, after -- after all the work you've</p> <p>25 done on this case over the last year or so -- your</p>

<p style="text-align: right;">3020</p> <p>1 consideration of your knowledge of antitrust economics, the</p> <p>2 determination of markets and market shares and concentration</p> <p>3 levels, study of the market, competitive affects, critical</p> <p>4 loss analysis, the procompetitive benefits -- what</p> <p>5 conclusion have you reached about the likely competitive</p> <p>6 effects of the Saltzer transaction?</p> <p>7 A. All those things that you've listed that I have</p> <p>8 evaluated and incorporated, I have taken advantage of my</p> <p>9 years of experience, and I think it's unlikely that this</p> <p>10 transaction would result in any harm to competition.</p> <p>11 I want to revisit for a minute the primary basis</p> <p>12 for that is the competitive dynamics in this market. We</p> <p>13 can't understand whether there is going to be a competitive</p> <p>14 problem without understanding that fully. And that, in many</p> <p>15 ways, trumps the market definition. The shares, the</p> <p>16 concentration, those are all useful things to look at and</p> <p>17 helpful indicia.</p> <p>18 But when it really comes down to trying to figure</p> <p>19 out whether it's going to make a difference, it's how these</p> <p>20 markets work and how that competitive dynamic between the</p> <p>21 two systems in their bargaining and relationships with the</p> <p>22 payors -- that's where their competitive alternatives comes,</p> <p>23 and that's the safety valve for the payors.</p> <p>24 THE COURT: "The systems" being St. Luke's and</p> <p>25 Saint Al's?</p>	<p style="text-align: right;">3021</p> <p>1 THE WITNESS: St. Luke's and Saint Al's, yes.</p> <p>2 And I think, as I mentioned, there are significant</p> <p>3 procompetitive benefits that will derive from this</p> <p>4 transaction as well.</p> <p>5 MR. STEIN: Your Honor, I have no further</p> <p>6 questions for Dr. Argue at this time.</p> <p>7 THE COURT: Yes, Mr. Herrick.</p> <p>8 CROSS-EXAMINATION</p> <p>9 BY MR. HERRICK:</p> <p>10 Q. Good morning, Dr. Argue.</p> <p>11 A. Good morning.</p> <p>12 Q. You have criticized Professor Dranove's analysis</p> <p>13 of bargaining dynamics; is that correct?</p> <p>14 A. I did have some comments on his bargaining-</p> <p>15 dynamics analysis.</p> <p>16 Q. But you agree that provider health plan</p> <p>17 negotiations focus on the percentage change in total</p> <p>18 payments for all services; is that correct?</p> <p>19 A. I believe that's what the evidence shows.</p> <p>20 Q. Now, you testified about the St. Luke's BCI</p> <p>21 negotiations in 2012; correct?</p> <p>22 A. Yes.</p> <p>23 Q. That occurred after St. Luke's became aware of the</p> <p>24 FTC's and the State of Idaho's investigation of this</p> <p>25 transaction; isn't that right?</p>
<p style="text-align: right;">3022</p> <p>1 A. That's my understanding.</p> <p>2 Q. Mr. Beilein, if you could please put slide 104</p> <p>3 from Dr. Argue's demonstratives on the screen.</p> <p>4 Now, Dr. Argue, you claim here that the transaction</p> <p>5 improves St. Luke's-Saltzer's ability to take on risk</p> <p>6 contracting; correct?</p> <p>7 A. I do say that.</p> <p>8 Q. You don't know whether St. Luke's could offer an</p> <p>9 attractive risk-based product to health plans without</p> <p>10 Saltzer; correct?</p> <p>11 A. I expect that St. Luke's could offer some form of</p> <p>12 risk-based contracting without Saltzer.</p> <p>13 Q. An attractive one?</p> <p>14 A. Attractive is a matter of degrees. As I just</p> <p>15 mentioned a few minutes ago, it depends on the price. The</p> <p>16 quality of the network can be adjusted by prices that are</p> <p>17 offered.</p> <p>18 Q. Well, you can't say yes or no whether risk-based</p> <p>19 contracting is a merger-specific benefit of this</p> <p>20 transaction; correct?</p> <p>21 A. I think that I can say that improvements in the</p> <p>22 ability to engage in risk-based contracting is a</p> <p>23 merger-specific benefit.</p> <p>24 MR. HERRICK: Mr. Beilein, if you could please</p> <p>25 play clip DA02. For the record, this is deposition</p>	<p style="text-align: right;">3023</p> <p>1 transcript page 20, lines 15 to 21.</p> <p>2 (Video clip played as follows:)</p> <p>3 Q. "Is it your opinion that risk-based</p> <p>4 contracting is a merger-specific benefit for</p> <p>5 this transaction?</p> <p>6 A. "Again, it's not a yes or no. I think</p> <p>7 there are benefits in terms of risk-based</p> <p>8 contracting capabilities for St. Luke's as a</p> <p>9 result of this transaction. But as I've just</p> <p>10 said in the last question, it doesn't mean they</p> <p>11 can't do it without. It's a matter of degree."</p> <p>12 (Video clip concluded.)</p> <p>13 BY MR. HERRICK:</p> <p>14 Q. Was that your testimony, Dr. Argue?</p> <p>15 A. Yes, it was.</p> <p>16 Q. And you haven't attempted to quantify in any way</p> <p>17 the difference between having Saltzer and not having Saltzer</p> <p>18 under St. Luke's ownership for purposes of risk-based</p> <p>19 contracting; correct?</p> <p>20 A. Quantify it? No, I have not.</p> <p>21 Q. And you haven't done any analysis that could put a</p> <p>22 specific number on that -- any percentage, any share;</p> <p>23 correct?</p> <p>24 A. I have no quantification, no numerical number that</p> <p>25 I can place for the benefit of that risk-based contracting.</p>

<p>3024</p> <p>1 Q. And, in fact, you're not sure how you would</p> <p>2 measure the benefits of risk-based contracting; correct?</p> <p>3 A. I believe I testified to that in my deposition</p> <p>4 that I don't know exactly how. I think there are different</p> <p>5 ways you might contemplate it, but I don't know exactly how</p> <p>6 you would do that.</p> <p>7 Q. Mr. Beilein, if you could please put slide 19 from</p> <p>8 Dr. Argue's demonstratives on the screen.</p> <p>9 Now, you mention here the shift from volume to value.</p> <p>10 But you didn't perform an independent empirical analysis of</p> <p>11 St. Luke's purported move from volume to value; correct?</p> <p>12 A. I guess I'm not quite sure what you mean by an</p> <p>13 "independent empirical analysis."</p> <p>14 MR. HERRICK: Mr. Beilein, if you could please</p> <p>15 play DA05. For the record, that's deposition transcript</p> <p>16 line -- page 46, line 22 to page 47, line 3.</p> <p>17 (Video clip played as follows:)</p> <p>18 Q. "If you could turn to paragraph 47 of your</p> <p>19 opening report. That section of your report</p> <p>20 describes the movement from volume to value.</p> <p>21 Do you see that?</p> <p>22 A. "Yes.</p> <p>23 Q. "Did you perform an independent empirical</p> <p>24 analysis of value in your opening report?</p> <p>25 A. "An independent empirical analysis, no."</p>	<p>3025</p> <p>1 (Video clip concluded.)</p> <p>2 BY MR. HERRICK:</p> <p>3 Q. Was that your testimony, Dr. Argue?</p> <p>4 A. That was my testimony.</p> <p>5 MR. STEIN: Your Honor, I suppose if counsel is</p> <p>6 offering this for some kind of admission, that's one issue.</p> <p>7 I would just note for the record he actually asked a</p> <p>8 different question in court than the question that was just</p> <p>9 played on the screen. So to the extent this is being</p> <p>10 introduced for impeachment, I would object.</p> <p>11 THE COURT: I guess I didn't catch the</p> <p>12 distinction. How is it different, Mr. Stein?</p> <p>13 MR. STEIN: I believe Mr. Herrick just asked him</p> <p>14 if he attempted to quantify the movement from volume to</p> <p>15 value.</p> <p>16 MR. HERRICK: That is not the question I asked.</p> <p>17 The question I asked was: You didn't perform an independent</p> <p>18 empirical analysis of St. Luke's purported move from volume</p> <p>19 to value; right?</p> <p>20 MR. STEIN: Which is a different question than the</p> <p>21 one that's here.</p> <p>22 MR. HERRICK: I would say it's a distinction</p> <p>23 without a difference, Your Honor.</p> <p>24 THE COURT: Let's go ahead and proceed.</p> <p>25 BY MR. HERRICK:</p>
<p>3026</p> <p>1 Q. You don't know whether Saltzer is subject to</p> <p>2 St. Luke's contract with SelectHealth; is that right?</p> <p>3 A. I did not at the time that I wrote my opening</p> <p>4 report. I understand now that Saltzer is part of the Select</p> <p>5 Medical Group -- I believe that's what it is -- and is</p> <p>6 therefore connected with the -- the SelectHealth contract.</p> <p>7 Q. So you didn't know that at the time of your</p> <p>8 opening report, your surrebuttal report, or your deposition;</p> <p>9 correct?</p> <p>10 A. That's probably true.</p> <p>11 Q. And St. Luke's could offer an attractive network</p> <p>12 for Nampa residents without Saltzer; correct?</p> <p>13 A. Could you repeat the question, please.</p> <p>14 Q. St. Luke's could offer an attractive network for</p> <p>15 Nampa residents without Saltzer; correct?</p> <p>16 A. Yes.</p> <p>17 Q. You didn't attempt to measure the appropriate</p> <p>18 scale for what St. Luke's is trying to achieve; correct?</p> <p>19 A. Scale with regard to what?</p> <p>20 MR. HERRICK: Perhaps -- let's just play the clip</p> <p>21 DA08. This is deposition transcript 46, lines 12 to 20.</p> <p>22 (Video clip played as follows:)</p> <p>23 Q. "Did you attempt to measure the</p> <p>24 appropriate scale for what St. Luke's is trying</p> <p>25 to achieve?</p>	<p>3027</p> <p>1 MR. SCHAFER: "Object to form.</p> <p>2 THE WITNESS: "I don't know that there's a magic number for</p> <p>3 scale, and I didn't intend to suggest that there was. I</p> <p>4 think there are benefits that come from greater scale. And</p> <p>5 those are, again, a matter of degree. In some cases, you get</p> <p>6 more benefits; in some cases, you get less, I suppose."</p> <p>7 (Video clip concluded.)</p> <p>8 BY MR. HERRICK:</p> <p>9 Q. Was that your testimony, Dr. Argue?</p> <p>10 A. Yes, it was.</p> <p>11 Q. In fact, St. Luke's -- excuse me. In fact,</p> <p>12 Saltzer is not a critical part of St. Luke's plan to move</p> <p>13 forward and develop vertical integration, improvements in</p> <p>14 quality of care, and reductions in cost; isn't that right?</p> <p>15 A. I believe that St. Luke's could accomplish all or</p> <p>16 most of those without Saltzer, but that there is more likely</p> <p>17 to have better outcomes with Saltzer.</p> <p>18 Q. I'll ask the question again -- I'll move on.</p> <p>19 Mr. Beilein, could you please put slide 108 from</p> <p>20 Dr. Argue's demonstratives on the screen.</p> <p>21 Now, here, Dr. Argue, you mention the difficulty of</p> <p>22 quantifying benefits for the transaction; is that right?</p> <p>23 A. Yes.</p> <p>24 Q. But you didn't attempt to measure the proposed</p> <p>25 transaction's efficiencies; correct?</p>

<p style="text-align: right;">3028</p> <p>1 A. That's correct.</p> <p>2 Q. And indeed, despite St. Luke's efforts to improve</p> <p>3 quality following prior acquisitions of physicians, you</p> <p>4 can't point to any specific quality improvements from those</p> <p>5 acquisitions; isn't that right?</p> <p>6 A. As this slide indicates, the integration itself is</p> <p>7 part of the importance -- important part of measuring those</p> <p>8 benefits and reduce costs and improve quality. It's in the</p> <p>9 early stages, but I have not measured any reduced</p> <p>10 utilization from previous acquisitions.</p> <p>11 Q. I will ask my question again. It's a very</p> <p>12 specific question.</p> <p>13 Despite St. Luke's efforts to improve quality following</p> <p>14 prior acquisitions of physicians, you can't point to any</p> <p>15 specific quality improvements from those acquisitions;</p> <p>16 correct?</p> <p>17 A. I do not have any specific quality improvements</p> <p>18 related to those previous acquisitions that I can point to.</p> <p>19 Q. In fact, you haven't done a systematic evaluation</p> <p>20 of quality improvements, right?</p> <p>21 A. That's correct.</p> <p>22 Q. And you don't have a systematic evaluation of cost</p> <p>23 reductions from those prior acquisitions, either; correct?</p> <p>24 A. That's correct.</p> <p>25 Q. And you don't know whether utilization of hospital</p>	<p style="text-align: right;">3029</p> <p>1 services declined following St. Luke's physicians</p> <p>2 acquisitions; is that right?</p> <p>3 A. That's correct.</p> <p>4 Q. In fact, you weren't able to quantify any</p> <p>5 particular benefits from St. Luke's previous acquisitions;</p> <p>6 is that right?</p> <p>7 A. As I said, I did not quantify any benefits from</p> <p>8 St. Luke's previous acquisitions.</p> <p>9 Q. Now, you haven't attempted to measure population</p> <p>10 health improvements as a result of any previous acquisitions</p> <p>11 by St. Luke's; correct?</p> <p>12 A. I haven't attempted to measure it. It doesn't</p> <p>13 mean it's not going to happen.</p> <p>14 Q. Indeed, you're not sure that St. Luke's is heavily</p> <p>15 engaged in population health management in the terms that</p> <p>16 you think of; right?</p> <p>17 A. I don't recall that -- that's correct. I don't</p> <p>18 know exactly what level of their population health</p> <p>19 management they're at at this stage.</p> <p>20 Q. And following St. Luke's acquisitions in the</p> <p>21 Magic Valley, you believe that pricing for hospital services</p> <p>22 went up at a faster rate than elsewhere in Idaho; isn't that</p> <p>23 right?</p> <p>24 A. I don't recall the comparison to the rest of the</p> <p>25 state. I know that prices -- hospital prices in Magic</p>
<p style="text-align: right;">3030</p> <p>1 Valley increased, at least for Blue Cross, at a faster clip</p> <p>2 there than some of the other areas that I looked at.</p> <p>3 Q. St. Luke's board didn't do anything to stop those</p> <p>4 price increases; right?</p> <p>5 A. I'm not aware of what St. Luke's board did.</p> <p>6 Q. Mr. Beilein, if you could please put slide 34 from</p> <p>7 Dr. Argue's demonstratives on the screen.</p> <p>8 This slide is entitled "Determining Actual Loss." This</p> <p>9 is where you talked about the break-even point yesterday;</p> <p>10 correct?</p> <p>11 A. That's correct.</p> <p>12 Q. Now, just to clarify some of the terminology here,</p> <p>13 you used the terms "predicted loss" and "actual loss"</p> <p>14 interchangeably; right?</p> <p>15 A. Yes.</p> <p>16 Q. In order to do a complete critical loss analysis,</p> <p>17 you need to compare the critical loss with the actual loss;</p> <p>18 right?</p> <p>19 A. You need to be able to understand what the balance</p> <p>20 is between the critical loss and the actual loss.</p> <p>21 Q. Earlier today, you said the antitrust question is:</p> <p>22 Would St. Luke's actual loss be more than the critical loss?</p> <p>23 Right?</p> <p>24 A. That's correct.</p> <p>25 Q. But you didn't calculate the actual loss for this</p>	<p style="text-align: right;">3031</p> <p>1 transaction; right?</p> <p>2 A. I think, as I stated yesterday, that there is no</p> <p>3 way to put your finger on a specific number. But all of my</p> <p>4 analysis focuses on what are the directions, how do you</p> <p>5 point toward the likelihood of that actual loss exceeding</p> <p>6 the critical loss. It's a likelihood measure, and I think</p> <p>7 there is a great likelihood that that critical loss would be</p> <p>8 exceeded by an actual loss.</p> <p>9 Q. I'm going to ask the question again, Dr. Argue.</p> <p>10 You did not calculate the actual loss for this</p> <p>11 transaction; correct?</p> <p>12 A. I did not calculate a specific number for the</p> <p>13 actual loss.</p> <p>14 Q. And that's because you couldn't calculate price</p> <p>15 elasticity; right?</p> <p>16 A. Price elasticity would be one thing that you would</p> <p>17 look at that may allow you to calculate the actual loss.</p> <p>18 Q. And you didn't do that; right?</p> <p>19 A. I did not have the information to do that.</p> <p>20 Q. Now, you relied on BCI and Regence data for your</p> <p>21 patient flow analysis; correct?</p> <p>22 A. Yes.</p> <p>23 Q. BCI and Regence are the two largest health plans</p> <p>24 in Idaho; is that right?</p> <p>25 A. Yes.</p>

<p style="text-align: right;">3032</p> <p>1 Q. Patients of BCI face the same price for all</p> <p>2 primary care physician services that they receive; is that</p> <p>3 right?</p> <p>4 A. I believe that's correct.</p> <p>5 Q. And the same is true for Regence?</p> <p>6 A. I think that's true.</p> <p>7 Q. So you agree that for a patient covered by BCI and</p> <p>8 Regence, it doesn't look like any price difference is what's</p> <p>9 causing the choice of the patient; correct?</p> <p>10 A. I'm sorry. What do you mean by "the choice of the</p> <p>11 patient"? In terms of the physician they have chosen?</p> <p>12 Q. Yes.</p> <p>13 A. That's correct. There are many other</p> <p>14 characteristics that go into the choice of the physician.</p> <p>15 In this case, for BCI and Regence, it's not a difference in</p> <p>16 the price.</p> <p>17 Q. As you sit here today, you can't point to any</p> <p>18 evidence in BCI or Regence's patient flow data that would</p> <p>19 explain travel for PCP services because of price; isn't that</p> <p>20 right?</p> <p>21 A. That's right. As I testified earlier today, the</p> <p>22 distribution of patients geographically that we're observing</p> <p>23 is a result of a number of different characteristics, one of</p> <p>24 which is price that the patients evaluate.</p> <p>25 Q. Now, the court asked you about a modest price</p>	<p style="text-align: right;">3033</p> <p>1 increase earlier. In economic terms, that would usually be</p> <p>2 referred to as a SSNIP; is that right?</p> <p>3 A. The merger guidelines refer to a SSNIP as a 5 to</p> <p>4 10 percent increase in price.</p> <p>5 Q. So, typically, in your analysis, do you think of a</p> <p>6 SSNIP as 5 percent?</p> <p>7 A. That's often the case.</p> <p>8 Q. Now, you don't know whether commercially insured</p> <p>9 patients who currently go to PCPs in Nampa would travel to</p> <p>10 Boise, for example, for those same services if St. Luke's</p> <p>11 and Saltzer were to raise their price by 5 percent; right?</p> <p>12 A. The evidence that I've looked at suggests to me</p> <p>13 that there is a good likelihood that some of the patients</p> <p>14 who are currently receiving their services with the Nampa</p> <p>15 PCPs could move to PCPs outside of Nampa and --</p> <p>16 Q. Dr. Argue, thank you. I'm asking a very specific</p> <p>17 question here.</p> <p>18 You don't know whether commercially insured patients</p> <p>19 who currently go to PCPs in Nampa would travel to Boise, for</p> <p>20 example, for those same services if St. Luke's and Saltzer</p> <p>21 were to raise their price by 5 percent; correct?</p> <p>22 A. I cannot give you a definitive answer that that</p> <p>23 would happen. I can give you some probabilities.</p> <p>24 Q. So you don't know; right?</p> <p>25 A. I just answered; I can't give you a definitive</p>
<p style="text-align: right;">3034</p> <p>1 answer for that.</p> <p>2 Q. The critical piece of your analysis is that there</p> <p>3 has to be some switching of PCPs as a result of a price</p> <p>4 change for critical loss to have an effect; correct?</p> <p>5 A. That's true. If you don't have the patient</p> <p>6 switching --</p> <p>7 Q. I'm sorry. Thank you.</p> <p>8 After you read Dr. Dranove's critique of your critical</p> <p>9 loss calculations, you revised your calculations for the</p> <p>10 critical loss for a 5 percent price increase from 6.8</p> <p>11 percent to 8.8 percent; is that right?</p> <p>12 A. That's correct.</p> <p>13 Q. And to be clear, you agreed with some of</p> <p>14 Dr. Dranove's criticisms of your opening report, and that's</p> <p>15 why you went back and revisited your calculations; right?</p> <p>16 A. I did not say I agreed with the positions</p> <p>17 that Dr. Dranove took. I said that his criticisms made me</p> <p>18 think that I ought to go back and reevaluate what I had</p> <p>19 done.</p> <p>20 Q. Well, you were concerned that you hadn't been</p> <p>21 thorough enough; right?</p> <p>22 A. That's the words I used.</p> <p>23 Q. And you went back and looked at it and agreed that</p> <p>24 Dr. Dranove was right; correct?</p> <p>25 A. No, I didn't.</p>	<p style="text-align: right;">3035</p> <p>1 MR. HERRICK: If you could play DA38, please.</p> <p>2 That's deposition transcript page 137, lines 9 through 18.</p> <p>3 (Video clip played as follows:)</p> <p>4 Q. "To be clear, you agreed with some of</p> <p>5 Dr. Dranove's criticisms of your opening</p> <p>6 report, and that's why you went back and</p> <p>7 revisited your calculations. Is that right?</p> <p>8 A. "Well, I was concerned that maybe I had</p> <p>9 been not thorough enough in relying on the</p> <p>10 interview entirely in the first place. So, I</p> <p>11 went back and looked at it and agreed that he</p> <p>12 is right, I should have gotten the detailed</p> <p>13 numbers there to prove up what I was relying</p> <p>14 on."</p> <p>15 (Video clip concluded.)</p> <p>16 BY MR. HERRICK:</p> <p>17 Q. Was that your testimony, Dr. Argue?</p> <p>18 A. That was my testimony, that I should have gotten</p> <p>19 the detailed numbers.</p> <p>20 Q. The change you made in revising your calculations</p> <p>21 amounted to almost a 30 percent increase in the critical</p> <p>22 loss threshold; correct?</p> <p>23 A. It was 2 percentage points.</p> <p>24 Q. And that's a 30 percent change; is that right?</p> <p>25 A. 30 percent increase of 6.8 would be about 8.8</p>

<p style="text-align: right;">3036</p> <p>1 percent, making it more difficult for St. Luke's to pass</p> <p>2 that threshold.</p> <p>3 Q. And that revision was based on some interviews and</p> <p>4 a worksheet provided by St. Luke's Joni Stright; is that</p> <p>5 right?</p> <p>6 A. That's was -- that's correct.</p> <p>7 Q. And other than your general experience and some</p> <p>8 articles, you haven't seen any evidence to substantiate the</p> <p>9 information that Ms. Stright provided to you; correct?</p> <p>10 A. I had no reason to doubt that the information she</p> <p>11 provided me was incorrect. I'm not going to go back and ask</p> <p>12 all of her administrators what -- whether the information</p> <p>13 they collected was correct.</p> <p>14 Q. Let me ask the question again.</p> <p>15 Other than your general experience and articles, you</p> <p>16 haven't seen any evidence to substantiate the information</p> <p>17 that Ms. Stright gave you; correct?</p> <p>18 A. That's correct.</p> <p>19 Q. Now, during your deposition, you said that it</p> <p>20 probably wouldn't affect your conclusions if that 8.8</p> <p>21 percent critical loss threshold were increased to 10</p> <p>22 percent; right?</p> <p>23 A. I think I said that.</p> <p>24 Q. When I asked you about a 15 percent critical loss</p> <p>25 threshold during your deposition, you said you needed to</p>	<p style="text-align: right;">3037</p> <p>1 check the data; right?</p> <p>2 A. I may have said that.</p> <p>3 Q. You can't just wing a number like that; right?</p> <p>4 A. What do you mean by "wing a number"?</p> <p>5 Q. Well, these are actually your words, Dr. Argue.</p> <p>6 Do you agree with that assessment?</p> <p>7 A. In the way I would interpret "wing a number," yes,</p> <p>8 I agree with that.</p> <p>9 Q. And that's because you don't have a predicted or</p> <p>10 actual loss to compare your critical loss number to; right?</p> <p>11 A. That's correct. There is no specific number for</p> <p>12 actual loss.</p> <p>13 Q. I mean, that's all this is; right? The critical</p> <p>14 loss is just a number; isn't that right?</p> <p>15 A. It's an objective benchmark, as I testified</p> <p>16 yesterday, which is just a number.</p> <p>17 Q. Now, you're not aware of any prior case involving</p> <p>18 a physician acquisition where critical loss has been used to</p> <p>19 establish a geographic market; right?</p> <p>20 A. I'm sorry. Any other case?</p> <p>21 Q. Any prior case involving a physician acquisition</p> <p>22 where critical loss has been used to establish a geographic</p> <p>23 market.</p> <p>24 A. I'm aware of no litigated case where that has</p> <p>25 happened.</p>
<p style="text-align: right;">3038</p> <p>1 Q. Now, the corrected version of your critical loss</p> <p>2 analysis, that was in your surrebuttal report; is that</p> <p>3 right?</p> <p>4 A. I believe that's correct.</p> <p>5 Q. And in -- in that surrebuttal report, you were</p> <p>6 responding to analyses by both Professor Haas-Wilson and</p> <p>7 Professor Dranove; correct?</p> <p>8 A. I believe that's right.</p> <p>9 Q. And in responding to Professor Haas-Wilson, you</p> <p>10 characterized one aspect of her analysis as, quote, "highly</p> <p>11 misleading," end quote; correct?</p> <p>12 A. I believe I did use that terminology.</p> <p>13 Q. But at your deposition, you recognize that your</p> <p>14 claim that Professor Haas-Wilson's analysis was, quote,</p> <p>15 "highly misleading," also applied to one of your own</p> <p>16 analyses in that same report; isn't that right?</p> <p>17 A. That could be. I don't recall.</p> <p>18 Q. Well, you admitted that there was a tension</p> <p>19 between your claim that Professor Haas-Wilson's analysis was</p> <p>20 highly misleading and your own analysis; right?</p> <p>21 A. I remember the expression. I don't remember</p> <p>22 specifically what it was I was referring to.</p> <p>23 Q. During your deposition, you couldn't offer any</p> <p>24 explanation for the tension between your criticisms of</p> <p>25 Professor Haas-Wilson and your own analysis; right?</p>	<p style="text-align: right;">3039</p> <p>1 A. I don't doubt that that's what I said. I don't</p> <p>2 remember what this -- what this whole subject is in</p> <p>3 reference to.</p> <p>4 Q. Well, in fact, you raised the possibility that you</p> <p>5 or your team -- I'm using your words here -- may have</p> <p>6 screwed up part of your analysis; is that right?</p> <p>7 MR. STEIN: Your Honor, I'm just going to object</p> <p>8 to the form. We're talking about "this analysis," "your</p> <p>9 analysis." Can we at least get -- I don't even know if</p> <p>10 we're talking about an analysis that Dr. Argue has testified</p> <p>11 about today, in which case it would be beyond -- if not, it</p> <p>12 would be beyond the scope.</p> <p>13 THE COURT: Why don't we clarify. It should be a</p> <p>14 fairly simple matter to clarify as to what analysis we're</p> <p>15 referring to.</p> <p>16 Now, the problem may be, of course, that may not track</p> <p>17 directly with a video or a deposition excerpt, but that also</p> <p>18 means I'll give you a little bit of leeway in terms of</p> <p>19 impeachment not exactly tracking with the question.</p> <p>20 MR. HERRICK: To clarify, Your Honor, this -- it's</p> <p>21 not necessarily germane as to what analysis we're talking</p> <p>22 about. It's really going to Dr. Argue's credibility.</p> <p>23 THE COURT: Well, if -- well, let's reask the</p> <p>24 question. I guess what -- I think Mr. Stein is right, that</p> <p>25 if we're going to use words such as "your analysis" -- well,</p>

<p style="text-align: right;">3040</p> <p>1 I guess if the question is you -- is phrased in terms of</p> <p>2 something that was not done as part of the analysis, that</p> <p>3 probably would be more generic in nature.</p> <p>4 Rephrase the question, and then Mr. Stein can restate</p> <p>5 the objection if he still has one. That will give me a</p> <p>6 chance to consider whether or not it does need to be more</p> <p>7 specific.</p> <p>8 MR. HERRICK: Your Honor, as a potential</p> <p>9 alternative, I could play the clip and ask the witness if</p> <p>10 that refreshes his recollection.</p> <p>11 MR. STEIN: Well, I'm looking at the clip. And I</p> <p>12 can tell you, again, it's preceded by a discussion -- now I</p> <p>13 see what it is. It's an analysis that hasn't been testified</p> <p>14 to today. So we're going to have to play a much longer clip</p> <p>15 than just a question and answer.</p> <p>16 THE COURT: Do you have access to the transcript</p> <p>17 so you can present that either by video or in written form</p> <p>18 so I can evaluate that question?</p> <p>19 MR. STEIN: I could. I mean, yes, I have a</p> <p>20 printed copy.</p> <p>21 THE COURT: Well, let's proceed in this fashion.</p> <p>22 You can do that on redirect. You can cover that and clarify</p> <p>23 that point on redirect. Let's go ahead and proceed.</p> <p>24 MR. HERRICK: Your Honor, just to clarify, what</p> <p>25 I'm proposing here is to play the clip to refresh the</p>	<p style="text-align: right;">3041</p> <p>1 witness's recollection. If that's -- if you would prefer</p> <p>2 that I just proceed with questions, that's fine, too.</p> <p>3 THE COURT: Just proceed with the question.</p> <p>4 MR. HERRICK: Okay.</p> <p>5 BY MR. HERRICK:</p> <p>6 Q. I'll reask the question, Dr. Argue.</p> <p>7 During your deposition, you raised the possibility that</p> <p>8 you or your team, to use your phrase, "may have screwed up"</p> <p>9 part of your analysis. Do you recall that?</p> <p>10 A. I do recall that. That was in reference to</p> <p>11 work -- response to Dr. Dranove. You had been putting this</p> <p>12 in the context of work that was done in response to</p> <p>13 Ms. Haas-Wilson. That's why I was confused about your</p> <p>14 question.</p> <p>15 Q. Fair enough. In any event, you had no</p> <p>16 explanation, to use your phrase again, of how your team or</p> <p>17 you didn't screw up; is that right?</p> <p>18 A. I did not have an explanation as to why that</p> <p>19 analysis appeared to be wrong.</p> <p>20 Q. Now, turning to Micron.</p> <p>21 Mr. Beilein, if you could please put up slide 24 from</p> <p>22 Dr. Argue's demonstratives on the screen. There it is.</p> <p>23 In your opening report, you cited Micron over a hundred</p> <p>24 times; is that right?</p> <p>25 A. I did. I believe you counted it as 135 times.</p>
<p style="text-align: right;">3042</p> <p>1 Q. I wasn't sure of the exact number. Thank you.</p> <p>2 Dr. Argue, if you could look at the center circle on</p> <p>3 the screen. You see the Micron Family Health Center?</p> <p>4 A. Yes.</p> <p>5 Q. That's the onsite clinic at Micron's headquarters;</p> <p>6 is that correct?</p> <p>7 A. That's correct.</p> <p>8 Q. Now, in your analysis, you didn't consider the</p> <p>9 convenience of getting PCP services at the onsite clinic for</p> <p>10 Micron employees; is that right?</p> <p>11 A. I didn't evaluate the onsite center in any</p> <p>12 specific way at all.</p> <p>13 Q. But you imagine that was a factor, the</p> <p>14 convenience, in some patients choosing that facility?</p> <p>15 A. Yes.</p> <p>16 Q. But you didn't attempt to quantify how much of a</p> <p>17 factor the convenience played versus price in your analysis;</p> <p>18 right?</p> <p>19 A. No, I did not.</p> <p>20 Q. If you could turn to slide 25, Mr. Beilein. And</p> <p>21 here we have the setup of Micron's tiered network product.</p> <p>22 Aside from price, you didn't consider any other factors</p> <p>23 that might have explained some of the shift in patients when</p> <p>24 Micron launched its network; right?</p> <p>25 A. I didn't specifically look at any of those other</p>	<p style="text-align: right;">3043</p> <p>1 than price.</p> <p>2 Q. Focusing on price, you didn't attempt to measure</p> <p>3 the actual dollar amount out-of-pocket difference for</p> <p>4 in-network Micron enrollees versus out-of-network Micron</p> <p>5 enrollees; right?</p> <p>6 A. That's correct.</p> <p>7 Q. Again, the court asked you a little bit earlier</p> <p>8 about a modest price increase, which I believe you agreed</p> <p>9 would be 5 percent in the economic parlance.</p> <p>10 Now, do you agree that the difference between</p> <p>11 St. Luke's -- which is out of network -- and Saint Al's --</p> <p>12 which is in network -- is probably much more substantial</p> <p>13 than a 5 percent price increase; right?</p> <p>14 A. Yes, I agree that the out-of-pocket costs for out</p> <p>15 of network is substantially greater than the out-of-pocket</p> <p>16 costs for in-network in one of the tiers.</p> <p>17 Q. And you haven't put a number on the percentage</p> <p>18 patients who would travel for PCP services in response to a</p> <p>19 5 percent price increase; right?</p> <p>20 A. I have not put a specific number on that.</p> <p>21 Q. Mr. Beilein, if you could put slide 104 from</p> <p>22 Dr. Argue's demonstratives on the screen.</p> <p>23 Now, here you talked about sharing the high cost of</p> <p>24 implementing IT systems as one of the purported benefits of</p> <p>25 the transaction; right?</p>

<p style="text-align: right;">3044</p> <p>1 A. Yes.</p> <p>2 Q. Now, Saltzer already has an EMR system; correct?</p> <p>3 A. They do have an EMR system.</p> <p>4 Q. So just having an EMR, that's not a</p> <p>5 merger-specific benefit from this transaction; right?</p> <p>6 A. That's correct.</p> <p>7 Q. Now, you haven't attempted to measure the benefits</p> <p>8 of having Saltzer on St. Luke's EMR, either; right?</p> <p>9 A. I have not on St. Luke's EMR or in the Epic</p> <p>10 broader IT system.</p> <p>11 Q. And you don't know the status of St. Luke's</p> <p>12 affiliate EMR program; right?</p> <p>13 A. I don't know the specifics of that.</p> <p>14 Q. You didn't look into that program at all; right?</p> <p>15 A. I'm aware of it. I didn't look into the specifics</p> <p>16 of it.</p> <p>17 Q. And you don't know whether St. Luke's would make</p> <p>18 that program available to Saltzer if Saltzer were divested;</p> <p>19 right?</p> <p>20 A. I don't recall specifically what the status of</p> <p>21 that would be.</p> <p>22 Q. And you don't know whether Saltzer would get the</p> <p>23 full benefit of the Epic system if Saltzer physicians are</p> <p>24 not employed by St. Luke's; correct?</p> <p>25 A. I expect they would not get the full benefit of</p>	<p style="text-align: right;">3045</p> <p>1 it, but I don't know specifically.</p> <p>2 Q. Mr. Beilein, if you could please put slide 106</p> <p>3 from Dr. Argue's demonstratives on the screen.</p> <p>4 I want to direct your attention to the second bullet,</p> <p>5 first sub-bullet. Here you mention the flow of information,</p> <p>6 communication with Epic IT system as a procompetitive</p> <p>7 benefit of the transaction; right?</p> <p>8 A. Yes.</p> <p>9 Q. But you don't know whether the sharing of</p> <p>10 information between EMR systems is a merger-specific benefit</p> <p>11 or not; correct?</p> <p>12 A. The sharing of information between two different</p> <p>13 EMR systems? Is that your question?</p> <p>14 Q. Yes.</p> <p>15 A. I would expect there may be some merger-specific</p> <p>16 benefits related to that. I think the broader benefit is</p> <p>17 getting them all on one EMR system, meaning Epic.</p> <p>18 Q. So you don't know -- but you don't know whether</p> <p>19 that sharing of information is a merger-specific benefit;</p> <p>20 correct?</p> <p>21 A. Correct.</p> <p>22 Q. Now, please take a look at the third bullet.</p> <p>23 There, it indicates that reduced utilization is a</p> <p>24 procompetitive benefit of the transaction; correct?</p> <p>25 A. What I discussed in my direct testimony a few</p>
<p style="text-align: right;">3046</p> <p>1 minutes ago was the changed financial incentives and the</p> <p>2 impact that that has on utilization.</p> <p>3 Q. Okay. We'll get to that.</p> <p>4 You haven't conducted any analysis of how St. Luke's</p> <p>5 will lower Saltzer's utilization; correct?</p> <p>6 A. That's correct.</p> <p>7 Q. But you agree that Saltzer physicians have a</p> <p>8 financial incentive to perform more services under the PSA</p> <p>9 with St. Luke's; correct?</p> <p>10 A. Insofar as they're paid based on a productivity</p> <p>11 basis, that's correct.</p> <p>12 Q. And you haven't attempted any kind of</p> <p>13 forward-looking measurement of quality improvements that</p> <p>14 might result from the Saltzer transaction; correct?</p> <p>15 A. I'm sorry. Could you repeat the question.</p> <p>16 Q. You have not attempted any kind of forward-looking</p> <p>17 measurement of quality improvements that might result from</p> <p>18 the Saltzer transaction; correct?</p> <p>19 A. I have no measure of improvements in quality on a</p> <p>20 forward-looking basis.</p> <p>21 MR. HERRICK: I have no further questions,</p> <p>22 Your Honor.</p> <p>23 THE COURT: Mr. Ettinger.</p> <p>24 MR. ETTINGER: Thank you, Your Honor.</p> <p>25 CROSS-EXAMINATION</p>	<p style="text-align: right;">3047</p> <p>1 BY MR. ETTINGER:</p> <p>2 Q. Dr. Argue, would you agree that the validity of</p> <p>3 your conclusions ought to be judged by the court based in</p> <p>4 part on the accuracy of the factual representations you made</p> <p>5 to the court and in part on the acceptability of your</p> <p>6 methodology in economics?</p> <p>7 A. I think that's fair.</p> <p>8 Q. Why don't we look at slide 67 on the issue of</p> <p>9 factual representations. This is your slide 67.</p> <p>10 Regence, you talk about Saltzer's views. And then you</p> <p>11 say in the last bullet, "Regence recognized reasoning,</p> <p>12 agreed to keep Saltzer at traditional rate."</p> <p>13 Are you representing to the court that this is an</p> <p>14 accurate representation of the testimony of Scott Clement of</p> <p>15 Regence?</p> <p>16 A. No, Mr. Ettinger. As I testified, I took all of</p> <p>17 this information from the testimony of Nancy Powell.</p> <p>18 Q. Nancy Powell didn't say a word about why Regence</p> <p>19 took the action it did, did she?</p> <p>20 A. I don't recall specifically.</p> <p>21 Q. And the best source as to why Regence acted would</p> <p>22 be the Regence executive, Mr. Clement; isn't that right?</p> <p>23 A. Mr. Clement would certainly be a good source of</p> <p>24 that.</p> <p>25 Q. But you ignored Mr. Clement's testimony in making</p>

<p style="text-align: right;">3048</p> <p>1 this statement in this slide; correct?</p> <p>2 A. I did not include any reference to Mr. Clement's</p> <p>3 testimony.</p> <p>4 Q. Okay. So you did say, "Regence (Scott Clement)</p> <p>5 recognized reasoning"; correct?</p> <p>6 A. I did say that. I also said this came from</p> <p>7 Nancy Powell.</p> <p>8 Q. You didn't say that on the slide, did you?</p> <p>9 A. Excuse me?</p> <p>10 Q. You said a minute ago Nancy Powell did not say why</p> <p>11 Regence acted; correct?</p> <p>12 A. I took this from Nancy Powell's testimony. I</p> <p>13 don't recall specifically her words.</p> <p>14 Q. Now, let's go on to methodology, and let's take a</p> <p>15 look at slide 54.</p> <p>16 You say in your first bullet here, "Two-System</p> <p>17 competition sufficient for competitive prices." Do you see</p> <p>18 that?</p> <p>19 A. I do.</p> <p>20 Q. And you're talking about two hospital systems;</p> <p>21 correct?</p> <p>22 A. I am.</p> <p>23 Q. And the <u>ProMedica</u> and the <u>Rockford</u> cases are two</p> <p>24 of the most recent hospital merger cases, are they not?</p> <p>25 A. That's correct, they are.</p>	<p style="text-align: right;">3049</p> <p>1 Q. And in both those cases, the court rejected the</p> <p>2 idea that two hospital systems remaining after the merger</p> <p>3 were sufficient for adequate competition; correct?</p> <p>4 A. That could be. I don't remember the specifics of</p> <p>5 those two cases.</p> <p>6 Q. And a market with two -- by the way, those are two</p> <p>7 of the very few recent hospital merger cases that have been</p> <p>8 litigated; correct?</p> <p>9 A. They are two recent ones in the last couple of</p> <p>10 years.</p> <p>11 Q. Okay. And isn't it the case that under the merger</p> <p>12 guidelines, the smallest HHI you can have in a two-hospital</p> <p>13 market is 5,000, as a matter of arithmetic?</p> <p>14 A. That's true.</p> <p>15 Q. And 5,000 is double the level at which market</p> <p>16 power is presumed under the merger guidelines?</p> <p>17 A. It's double the 2500 threshold in the merger</p> <p>18 guidelines.</p> <p>19 Q. By the way, you talked about bargaining markets.</p> <p>20 The merger guidelines specifically address bargaining</p> <p>21 markets, don't they?</p> <p>22 A. They do address bargaining markets.</p> <p>23 Q. They don't say there is a special two-competitor</p> <p>24 exception in bargaining markets, do they?</p> <p>25 A. No, they don't say that. They don't say that</p>
<p style="text-align: right;">3050</p> <p>1 there isn't one, either.</p> <p>2 Q. And they don't say anything about changing the HHI</p> <p>3 standards for bargaining markets, do they?</p> <p>4 A. They do not.</p> <p>5 Q. And you can't think of any area of the merger</p> <p>6 guidelines that you believe should not be applied to</p> <p>7 physician mergers; correct?</p> <p>8 A. I wouldn't say that.</p> <p>9 MR. ETTINGER: Keely, why don't we play clip 23.</p> <p>10 Your Honor, this is Dr. Argue's deposition at page 158,</p> <p>11 lines 19 to 23.</p> <p>12 (Video clip played as follows:)</p> <p>13 Q. "Well, let me ask just ask you, would you</p> <p>14 say there are any aspects of the merger</p> <p>15 guidelines that as a general matter as applied</p> <p>16 to physician mergers you would not agree with?</p> <p>17 A. "I can't think of any off the top of my</p> <p>18 head."</p> <p>19 (Video clip concluded.)</p> <p>20 MR. STEIN: Your Honor, I'm going to object on the</p> <p>21 rule of completeness. That is followed by a previous</p> <p>22 question in which Dr. Argue says basically what he has just</p> <p>23 testified to on the stand.</p> <p>24 MR. ETTINGER: Your Honor, I don't think that's</p> <p>25 right, but Mr. Stein can bring it up on redirect if it's</p>	<p style="text-align: right;">3051</p> <p>1 true.</p> <p>2 THE COURT: Mr. Stein, generally I have you do</p> <p>3 that on redirect unless it's so misleading that it needs to</p> <p>4 immediately be addressed. With no jury here, I don't see</p> <p>5 any need for that in any event. So if you'll just bring</p> <p>6 that up on redirect.</p> <p>7 BY MR. ETTINGER:</p> <p>8 Q. Dr. Argue, HHIs are based on market shares, are</p> <p>9 they not?</p> <p>10 A. They are.</p> <p>11 Q. They're not based on the share of one company's</p> <p>12 employees, are they?</p> <p>13 A. That's correct.</p> <p>14 Q. And nobody would -- no economist would calculate a</p> <p>15 proper HHI based on share of one company's employees, would</p> <p>16 he?</p> <p>17 A. Not likely.</p> <p>18 Q. Why don't we look at slide 53. What you did here</p> <p>19 was you did an illustration of HHIs using shares of Micron's</p> <p>20 employees; correct?</p> <p>21 A. I --</p> <p>22 Q. Is that correct? Yes or no, please.</p> <p>23 A. That's exactly what the title says.</p> <p>24 Q. Using Micron's health plan employees; correct?</p> <p>25 A. That's correct.</p>

3052

3053

1 **Q.** Thank you. Let's talk a little bit more about
2 critical loss. Now, if I understand your testimony, for the
3 actual loss to exceed the critical loss, you would need to
4 have more than 8.8 percent of the patients to switch due to
5 price or another financial incentive; correct?

6 **A.** Largely. I mean, it's possible that there is some
7 switching based on quality changes, but we're focusing
8 mostly on price changes.

9 **Q.** If the question is can somebody successfully
10 exercise market power by raising prices -- which is what
11 you've talked about today -- then the question is will more
12 than 8.8 percent of the patients in the proposed market
13 switch due to price or other financial incentives; correct?

14 **A.** Correct.

15 **Q.** And that's 8.8 percent of all the patients in that
16 market; is that correct?

17 **A.** It's 8.8 percent of the patients who are
18 commercially insured in that market.

19 **Q.** Correct. So if, for example, only 10 percent of
20 the commercially insured patients have financial incentives
21 which are affected by their choice of providers, then 88
22 percent of that 10 percent would have to switch for the
23 actual loss to exceed the critical loss; correct?

24 **A.** If there are no other changes.

25 **Q.** So it becomes pretty germane as to whether more

1 than 10 percent or so of the people in the -- strike that.
2 Let me just go on to another slide. 27, your slide 27.

3 And this is your list of companies with tiered or
4 directed benefits. Do you see that?

5 **A.** That's correct. Those are the ones I'm aware of.

6 **Q.** Now, Thomas Cuisine has 80 employees; isn't that
7 right?

8 **A.** I don't know the exact number of employees.

9 **Q.** And Paul's Market has had one claim so far under
10 their contract; isn't that right?

11 **A.** I don't know how many claims Paul's Market has
12 had.

13 **Q.** Have you read any deposition testimony on these
14 companies or trial testimony?

15 **A.** I just heard about Thomas Cuisine in trial
16 testimony. I have not read any deposition testimony related
17 to Paul's in particular.

18 **Q.** Did you read trial testimony about Thomas Cuisine
19 and Paul's?

20 **A.** I did. I don't remember specifically.

21 **Q.** And Woodgrain actually has a wide network for
22 physicians through IPN, does it not?

23 **A.** It does use IPN.

24 **Q.** And that's a wide, not a narrow, network; correct?

25 **A.** That's true.

3054

3055

1 **Q.** And Boise Schools and Idaho Power actually dropped
2 their directed benefits programs, didn't they?

3 **A.** They have discontinued their benefits program.

4 **Q.** And you don't know how many Treasure Valley
5 employers in the future would be more likely to follow the
6 Idaho Power approach versus the Micron approach; correct?

7 **A.** I don't know what the employers are going to do in
8 the future.

9 **Q.** And certainly Micron's success with its benefit
10 design doesn't tell you what other employers will want to
11 do, does it?

12 **A.** It does not tell me what they will want to do. I
13 can't read their minds.

14 **Q.** And you cannot say to what degree the behavior of
15 Micron employees is attributable to those employees'
16 concerns about the company and their jobs as opposed to
17 benefit design; correct?

18 **A.** I don't have any specific information related to
19 that.

20 **Q.** And you don't know even approximately what
21 percentage of covered lives nationally are subject to
22 financial incentives that would shift patients; correct?

23 **A.** I don't know the answer to that.

24 **Q.** You don't know if that number is small or large,
25 growing or not, do you?

1 **A.** I expect that it's growing, but I don't know for
2 sure.

3 **Q.** Now, Micron established its program about five
4 years ago; correct?

5 **A.** In 2008.

6 **Q.** And Walmart has just joined in after five years or
7 so; is that right?

8 **A.** Walmart joined in the beginning of 2013.

9 **Q.** And you don't know if it will take five or ten
10 more years or longer, if ever, until a substantial number of
11 Treasure Valley employees are covered by tiered plans or
12 plans with narrow networks; correct?

13 **A.** I don't know the answer to that. It depends in
14 part on what's happening in the market.

15 **Q.** And your opinion on market definition, though, is
16 given as of today; correct?

17 **A.** My opinion on market definition, yes. My opinion
18 on competitive effects takes into account lots of different
19 factors.

20 **Q.** Is your opinion on competitive effects an opinion
21 as to what would happen today as a result of this deal, or
22 are you confining yourself to what might happen five or ten
23 years in the future?

24 **A.** A lot of my testimony is trying to anticipate what
25 might happen if there were a 5 to 10 percent price increase.

<p style="text-align: right;">3056</p> <p>1 Q. My question is: Is your testimony about the</p> <p>2 competitive effects that would occur today if this</p> <p>3 transaction occurred? Yes or no?</p> <p>4 A. Yes, it's about what I understand from the market</p> <p>5 today.</p> <p>6 Q. Now, you said you did not define an outside</p> <p>7 geographic market in this case. Was that your testimony on</p> <p>8 direct?</p> <p>9 A. I think I had said an outside boundary of the</p> <p>10 geographic market.</p> <p>11 Q. You did, in fact, initially, until we discussed</p> <p>12 the matter in your deposition, have a specific definition of</p> <p>13 a relevant geographic market in this case, didn't you?</p> <p>14 A. And I think I termed it as a relevant market. No,</p> <p>15 I think what I had actually -- certainly in the context of</p> <p>16 my report in the discussion in my deposition, I referred to</p> <p>17 it as at least as big as.</p> <p>18 Q. Well, in fact, didn't you say that the primary</p> <p>19 care physicians in the relevant geographic market are the</p> <p>20 physicians in Nampa, Caldwell, Meridian, and West Boise?</p> <p>21 A. I believe that's my language.</p> <p>22 Q. And there is almost 40 percent out-migration from</p> <p>23 that area; correct?</p> <p>24 A. There is.</p> <p>25 Q. And you said in your report that 40 percent -- an</p>	<p style="text-align: right;">3057</p> <p>1 area with 40 percent out-migration cannot constitute a</p> <p>2 relevant market; correct?</p> <p>3 A. I did say that.</p> <p>4 Q. And so you cannot say today what the properly</p> <p>5 defined geographic market for primary care is in this case;</p> <p>6 correct?</p> <p>7 A. I believe it's at least as big as the areas I</p> <p>8 specified, but I can't put my finger on an exact boundary.</p> <p>9 Q. Now, you don't know of any payor in the Treasure</p> <p>10 Valley that has ever tried to sell a network without Nampa</p> <p>11 primary care physicians; correct?</p> <p>12 A. Correct.</p> <p>13 Q. And you agree that it would be very hard for a</p> <p>14 payor in the Treasure Valley to successfully sell a product</p> <p>15 with a network without pediatricians; correct?</p> <p>16 A. Throughout the entire Treasure Valley, a network</p> <p>17 without pediatricians, I expect that would be difficult.</p> <p>18 Q. And your reason as to why that's difficult is</p> <p>19 because some families want pediatricians and would be</p> <p>20 willing to leave in order to find one; correct?</p> <p>21 A. That's correct. Some families would want</p> <p>22 pediatricians.</p> <p>23 Q. Now, you didn't consider the costs associated with</p> <p>24 travel in your geographic market analysis, did you?</p> <p>25 A. I didn't consider it explicitly. I just observed</p>
<p style="text-align: right;">3058</p> <p>1 the travel patterns in the patient origin data.</p> <p>2 Q. So you didn't calculate any travel costs?</p> <p>3 A. That's correct.</p> <p>4 Q. And you didn't consider the costs associated with</p> <p>5 travel time, did you?</p> <p>6 A. No, I did not.</p> <p>7 Q. Let's talk about referrals and the vertical issue</p> <p>8 for just a bit. Let's go to slide 9 of your PowerPoint. I</p> <p>9 want to go to the third bullet. You said this a little bit</p> <p>10 differently on direct, if I heard you correctly. I just</p> <p>11 want to be sure that this represents your views.</p> <p>12 I'm going to what should be a "B" down there, but the</p> <p>13 "B" is missing. Is it correct that it is your view that for</p> <p>14 harm to competitors to rise to the level of harm to</p> <p>15 competition, the losses would have to be enough to diminish</p> <p>16 substantially the competitive constraint they place on</p> <p>17 St. Luke's?</p> <p>18 A. I believe that's correct.</p> <p>19 Q. Now, you agree, do you not, that many patients do</p> <p>20 not have a preference about where they are hospitalized and</p> <p>21 will just follow their physicians' recommendations?</p> <p>22 A. I believe that's true.</p> <p>23 Q. And also, you believe that, based on the</p> <p>24 St. Luke's data you examined, there is a direct relationship</p> <p>25 between the gain or loss of patients for physician services</p>	<p style="text-align: right;">3059</p> <p>1 and the gain or loss of patients for hospitalization?</p> <p>2 A. I testified to that, yes.</p> <p>3 Q. Now, you talked about the three physicians who</p> <p>4 testified here. I have got a couple very specific questions</p> <p>5 about them.</p> <p>6 Isn't it true that for all three groups of those</p> <p>7 physicians, that after they were acquired -- and by</p> <p>8 "groups," I mean those physicians who were acquired or in</p> <p>9 the IPA example -- for example -- that all three of these</p> <p>10 groups after the acquisitions saw their cases at Saint Al's</p> <p>11 drop by more than 90 percent for those patients who had not</p> <p>12 seen the SAMG primary care doctor?</p> <p>13 A. I believe that's correct. Since they all</p> <p>14 discontinued their privileges, they wouldn't have been doing</p> <p>15 much work at Saint Al's.</p> <p>16 Q. And the same was true for their outpatient cases</p> <p>17 and for their specialty referrals; isn't that right?</p> <p>18 A. That's probably true.</p> <p>19 Q. Both of which they could have continued to do even</p> <p>20 without the privileges; correct?</p> <p>21 A. I suppose that's true.</p> <p>22 Q. Now, let's talk about your slides on the primary</p> <p>23 care groups and acquisitions. Some of this you may have</p> <p>24 said to Mr. Stein, but I just want to be sure the record is</p> <p>25 clear.</p>

<p style="text-align: right;">3060</p> <p>1 So the data you looked at there did not specifically</p> <p>2 identify what doctor referred; correct?</p> <p>3 A. That's correct.</p> <p>4 Q. And it did not specifically identify what doctor</p> <p>5 made the admission; correct?</p> <p>6 A. That's correct.</p> <p>7 Q. You basically looked at a patient, said what</p> <p>8 specialist has that patient seen, what primary care doctor</p> <p>9 has that patient seen; correct?</p> <p>10 A. That's what I testified to.</p> <p>11 Q. So that data does not tell you when or if that</p> <p>12 patient was first referred to that specialist by the primary</p> <p>13 care doctor; correct?</p> <p>14 A. As I explained in discussing my methodology, I</p> <p>15 don't have specific information about the referrals. So the</p> <p>16 answer to your question is, yes, that's correct.</p> <p>17 Q. And therefore, your data doesn't tell you for any</p> <p>18 patient visit to a specialist whether the referral by the</p> <p>19 primary care physician to that specialist may have preceded</p> <p>20 the acquisition of the primary care group even if the</p> <p>21 specialist visit you looked at was after the acquisition;</p> <p>22 correct?</p> <p>23 A. I think it's unlikely given the methodology I</p> <p>24 used.</p> <p>25 Q. Do you know how long patients typically stay with</p>	<p style="text-align: right;">3061</p> <p>1 specialists if they have got a chronic condition?</p> <p>2 A. I don't know specifically.</p> <p>3 Q. The fact is that your data doesn't tell you the</p> <p>4 degree to which a specialist visit by a patient that may</p> <p>5 have occurred after the acquisition of the primary care</p> <p>6 group was based on a referral by the primary care physician</p> <p>7 before the acquisition; correct?</p> <p>8 A. It's possible that there were some patients in</p> <p>9 that category. I think that it's unlikely.</p> <p>10 Q. Well, in fact, you cannot assess, and you didn't</p> <p>11 try to assess, even approximately the frequency with which</p> <p>12 patients of primary care physicians whose practices have</p> <p>13 been acquired by St. Luke's have a hospital admission after</p> <p>14 the acquisition that's not attributable in any way to the</p> <p>15 actions of the primary care physician after the acquisition?</p> <p>16 A. I did not have the information to assess that.</p> <p>17 Q. Thank you. Now, your data --</p> <p>18 THE COURT: Counsel, could I just inquire.</p> <p>19 The evaluation you did was not really an evaluation in</p> <p>20 referrals. It was an evaluation of correlation between</p> <p>21 seeing a primary care physician for -- at a time prior to</p> <p>22 that patient going to a specialist or for a hospitalization;</p> <p>23 is that correct?</p> <p>24 THE WITNESS: That's right. That's why I used the</p> <p>25 term "attribute." We attribute a patient to a primary care</p>
<p style="text-align: right;">3062</p> <p>1 physician based on the most recent visit that they had. I</p> <p>2 can't specifically in the data link this -- yes, this was a</p> <p>3 referral from "PCP A" to "Specialist B." But I can look at</p> <p>4 it in the patterns of the data and try to get as close an</p> <p>5 understanding as possible.</p> <p>6 THE COURT: So to follow up, I think, on</p> <p>7 Mr. Ettinger's comment, if -- again, as I get older, I start</p> <p>8 thinking more about chronic problems and how you respond to</p> <p>9 those chronic problems.</p> <p>10 So if, hypothetically speaking, an individual were to</p> <p>11 see a physician on day one and be referred to an</p> <p>12 otolaryngologist on a later date, there may be a tendency on</p> <p>13 a chronic condition for that patient to remain with that</p> <p>14 otolaryngologist regardless of what affiliation the original</p> <p>15 primary care physician may have had and regardless of</p> <p>16 whether that affiliation may change over time.</p> <p>17 So I would keep -- so a hypothetical patient might keep</p> <p>18 a specialist and a primary care physician who originally</p> <p>19 were linked -- but later that link was broken because of an</p> <p>20 acquisition -- simply because you like both the specialist</p> <p>21 and the primary care physician.</p> <p>22 THE WITNESS: It certainly is possible that that</p> <p>23 could happen.</p> <p>24 THE COURT: You can't measure it, is the problem.</p> <p>25 THE WITNESS: The data limitations only can do</p>	<p style="text-align: right;">3063</p> <p>1 what I can.</p> <p>2 THE COURT: Mr. Ettinger, go ahead.</p> <p>3 BY MR. ETTINGER:</p> <p>4 Q. Now, this data problem we have been talking about</p> <p>5 is a function of the way you specifically looked at the</p> <p>6 data, which was different than how Professor Haas-Wilson</p> <p>7 utilized the data; correct?</p> <p>8 A. My understanding of --</p> <p>9 Q. Yes or no, please. Isn't it true that what we</p> <p>10 have been talking about is a function of the specific way</p> <p>11 you looked at the data?</p> <p>12 A. That was not your first question. But the answer</p> <p>13 to your question is, yes, it's part of the function of my</p> <p>14 methodology.</p> <p>15 Q. Okay. I think it was a better question, so you</p> <p>16 gave me a quick answer. Thank you.</p> <p>17 Now, even given these issues, your data, in fact,</p> <p>18 showed that referrals by the PCP groups you looked at to</p> <p>19 St. Luke's specialists increased by more than 50 percent</p> <p>20 after they were acquired by St. Luke's; isn't that right?</p> <p>21 A. I'm sorry. Please run that question by me again.</p> <p>22 Q. Isn't it true that your data showed that referrals</p> <p>23 by these PCP groups you looked at to St. Luke's specialists</p> <p>24 increased by more than 50 percent after the acquisitions of</p> <p>25 these groups?</p>

<p style="text-align: right;">3064</p> <p>1 A. Yes, but there is a good reason or a reason that I</p> <p>2 could explain if you're interested.</p> <p>3 Q. Let's talk very briefly about entry and excess</p> <p>4 capacity, Dr. Argue -- actually, just excess capacity</p> <p>5 because that's what you focused on.</p> <p>6 Excess capacity in a physician group is another way of</p> <p>7 saying these doctors are not very busy; isn't that right?</p> <p>8 A. It means they have got extra time, I guess.</p> <p>9 Q. And that means they may not have been able to</p> <p>10 attract enough patients to fill their schedules; correct?</p> <p>11 A. That could be part of the reason.</p> <p>12 Q. Now, you talked about the amount of entry or</p> <p>13 expansion that would be sufficient to avoid anticompetitive</p> <p>14 harm, and you talked about it with regard to the horizontal</p> <p>15 issues in the case.</p> <p>16 Isn't it true that to the extent one is concerned about</p> <p>17 foreclosure, you would need sufficient entry to take enough</p> <p>18 business from Saltzer so that -- so that a worry about</p> <p>19 shifting referrals would no longer be a concern?</p> <p>20 A. If there were actually a concern about</p> <p>21 foreclosure -- competitive foreclosure, that's true.</p> <p>22 MR. ETTINGER: I have no further questions. Thank</p> <p>23 you.</p> <p>24 THE COURT: Redirect.</p> <p>25 REDIRECT EXAMINATION</p>	<p style="text-align: right;">3065</p> <p>1 BY MR. STEIN:</p> <p>2 Q. Dr. Argue, since it's most top of mind, can you</p> <p>3 explain to the court what additional information you wanted</p> <p>4 to convey with regard to the claimed increase in referrals</p> <p>5 to St. Luke's following acquisitions?</p> <p>6 A. What happens here in this post-acquisition period</p> <p>7 is St. Luke's has been acquiring any number of physician</p> <p>8 practices, specialty practices. We include those in that</p> <p>9 St. Luke's referral column. So it's not the same group</p> <p>10 before as after.</p> <p>11 And that's sort of an artificial -- not</p> <p>12 artificial. It's just an increase in referrals to</p> <p>13 St. Luke's. Obviously, most of my focus has been on</p> <p>14 referrals to Saint Al's.</p> <p>15 Q. And does the volume of referrals to St. Luke's</p> <p>16 before and after tell you anything about whether Saint Al's</p> <p>17 has suffered anticompetitive foreclosure as a result of an</p> <p>18 acquisition?</p> <p>19 A. Not at all.</p> <p>20 Q. Okay. So, for example, if we just take some basic</p> <p>21 numbers, if Saint Al's was getting 100 admissions before the</p> <p>22 acquisition and 100 admissions after, but St. Luke's was</p> <p>23 actually getting more admissions because maybe other doctors</p> <p>24 were sending these acquired doctors more patients, would you</p> <p>25 conclude in any way that Saint Al's has suffered</p>
<p style="text-align: right;">3066</p> <p>1 anticompetitive foreclosure?</p> <p>2 A. I would not conclude that.</p> <p>3 Q. And Mr. Ettinger asked you a question which,</p> <p>4 frankly, I found a little confusing, so I want to make sure</p> <p>5 I understand your answer.</p> <p>6 He asked you whether -- the fact that you didn't</p> <p>7 identify referrals was a problem -- a function of the</p> <p>8 specific way you looked at the data. Can you explain what</p> <p>9 that means or what you understood it to mean when you</p> <p>10 answered yes?</p> <p>11 A. Can you repeat it, please.</p> <p>12 Q. Yes. You said -- when you talked about the fact</p> <p>13 that you did not look at the data and identify specific</p> <p>14 referrals, Mr. Ettinger asked you, "And that's a function of</p> <p>15 the specific way you looked at the data?" And you said yes.</p> <p>16 What does that mean?</p> <p>17 A. No, that's not an appropriate answer. As I</p> <p>18 explained to Your Honor, the data do not have a referral</p> <p>19 connection. I can look at it all I want, and I am never</p> <p>20 going to find a referral connection in there. It's just a</p> <p>21 function of the data itself.</p> <p>22 Q. I see. But it sounds like, from Mr. Ettinger's</p> <p>23 questions, Professor Haas-Wilson found some magic way to</p> <p>24 specifically tie an admission or specialist referral to a</p> <p>25 specific referral in whatever data she looked at; is that</p>	<p style="text-align: right;">3067</p> <p>1 right?</p> <p>2 A. No. I think she and I approached that data in a</p> <p>3 very similar fashion, both trying to attribute a patient to</p> <p>4 a physician.</p> <p>5 Q. Well, I'm confused, Dr. Argue. Because</p> <p>6 Mr. Ettinger -- I'm sorry -- plaintiffs' counsel asked you</p> <p>7 some questions in which he talked about how Professor</p> <p>8 Haas-Wilson had looked at referrals to St. Luke's-acquired</p> <p>9 doctors or practices from SAMG physicians and nonSAMG</p> <p>10 physicians. Do you recall that?</p> <p>11 A. I do.</p> <p>12 Q. So how did Professor Haas-Wilson in her analysis</p> <p>13 identify whether a patient would be attributed to a SAMG</p> <p>14 physician or a nonSAMG physician?</p> <p>15 A. With the Regence and the Blue Cross data, there is</p> <p>16 no way to do it other than the way that I've talked about,</p> <p>17 which is very similar to the way that Professor Haas-Wilson</p> <p>18 has done it.</p> <p>19 Q. And do I understand, is what Professor Haas-Wilson</p> <p>20 did look at an inpatient admission to Saint Al's and then</p> <p>21 identify it as a SAMG -- as related to a SAMG doctor or a</p> <p>22 nonSAMG doctor just purely based on the -- whether there was</p> <p>23 some -- whether the patient had seen a SAMG or nonSAMG</p> <p>24 doctor in some period of time before the admission?</p> <p>25 A. I believe that's right. That's my understanding</p>

<p style="text-align: right;">3068</p> <p>1 of her methodology.</p> <p>2 Q. And what time period did Professor Haas-Wilson use</p> <p>3 in her analyses? In other words, when she looked at the</p> <p>4 data and said there was an inpatient admission and the</p> <p>5 patient also saw a SAMG doctor, how far back before the</p> <p>6 admission did she go and feel comfortable saying that</p> <p>7 referral was attributable -- the admission was attributable</p> <p>8 to the SAMG doctor?</p> <p>9 A. I don't remember exactly. It was some number of</p> <p>10 weeks. It was not substantially different than my approach.</p> <p>11 Q. Was it more than eight weeks?</p> <p>12 A. I think -- I think it was less.</p> <p>13 Q. And when you did your -- when you did your</p> <p>14 eight-week analysis, you did test alternative sensitivities</p> <p>15 to see whether, if you tweaked the numbers or tweaked the</p> <p>16 weeks, maybe you could get substantially different results?</p> <p>17 A. That's right. I think I testified we did as much</p> <p>18 as a 29-week period to link between the physician and the</p> <p>19 patient.</p> <p>20 Q. So let me go back and start with some of the</p> <p>21 questions that Mr. Herrick asked you. It sounds like you</p> <p>22 basically testified that when it comes to measuring the</p> <p>23 procompetitive benefits, that you didn't -- and the word</p> <p>24 that was used repeatedly was "quantify" the procompetitive</p> <p>25 benefits -- why didn't you put a specific number,</p>	<p style="text-align: right;">3069</p> <p>1 quantification on the procompetitive benefits?</p> <p>2 A. These -- it's -- as I said, it's difficult to</p> <p>3 quantify these in the first place, and there has been a lot</p> <p>4 of testimony about the benefits that are going to come.</p> <p>5 But the other point that I mentioned in the</p> <p>6 response to Mr. Herrick is that -- there are a couple of</p> <p>7 things. One is this is starting up. This program, this</p> <p>8 integration that St. Luke's is working on, it's not in its</p> <p>9 final stages. It's in process.</p> <p>10 But the other part is that this -- the IT system,</p> <p>11 the Epic system, that St. Luke's is implementing is going to</p> <p>12 be how they quantify those benefits. We're talking about</p> <p>13 increasing in value-based care, which is talking about</p> <p>14 improving quality and reducing cost. If you don't measure</p> <p>15 them, you can't tell whether you're making improvements, and</p> <p>16 the Epic system is a key part of doing that measurement.</p> <p>17 Q. And even if you had been able to somehow quantify</p> <p>18 the procompetitive benefits, did Professor Haas-Wilson or</p> <p>19 Dr. Dranove make any attempt to quantify the alleged</p> <p>20 anticompetitive effects?</p> <p>21 A. No. They said there were anticompetitive effects,</p> <p>22 but they didn't quantify them.</p> <p>23 Q. Now, counsel for the Federal Trade Commission also</p> <p>24 asked you a question to the effect of whether St. Luke's</p> <p>25 would be able to proceed with risk-based contracting and</p>
<p style="text-align: right;">3070</p> <p>1 quality improvements without Saltzer. And I think you said</p> <p>2 the answer was yes; is that right?</p> <p>3 A. Yes.</p> <p>4 Q. Do you know whether St. Luke's would be able</p> <p>5 to -- that it would succeed in the same way it would or at</p> <p>6 all without Saltzer as if it had Saltzer as part of</p> <p>7 St. Luke's?</p> <p>8 A. I think part of my testimony was that it would be</p> <p>9 likely to succeed in a more comprehensive manner if it had</p> <p>10 Saltzer as part of the system.</p> <p>11 Q. Now, of course, there's two parties to this</p> <p>12 transaction, so let me ask a little different question.</p> <p>13 How likely is it that Saltzer if it's not part of</p> <p>14 St. Luke's is going to be able to achieve the benefits of</p> <p>15 risk-based contracting and the types of quality improvements</p> <p>16 that St. Luke's is moving forward with?</p> <p>17 A. I think it's very unlikely as a freestanding</p> <p>18 physician organization that it could replicate those</p> <p>19 benefits.</p> <p>20 Q. You were also asked some questions about prices in</p> <p>21 the Magic Valley, and I believe you testified that -- I</p> <p>22 think the question was "Did prices go up after the date that</p> <p>23 St. Luke's acquired the Magic Valley Medical Center?" Is</p> <p>24 that right?</p> <p>25 A. Yes, I recall that.</p>	<p style="text-align: right;">3071</p> <p>1 Q. Or maybe at a rate greater than elsewhere in the</p> <p>2 state. Was that --</p> <p>3 A. Yes, I believe that's right.</p> <p>4 Q. And where were the prices in the Magic Valley</p> <p>5 starting from relative to other hospitals in the state at</p> <p>6 the time that the increase that was experienced in the</p> <p>7 Magic Valley was greater?</p> <p>8 A. Magic Valley prices at the time of St. Luke's</p> <p>9 acquisition were substantially below the rates in other</p> <p>10 parts of the state.</p> <p>11 Q. And had the plaintiffs done any analysis that</p> <p>12 you're aware of that demonstrates that prices in the</p> <p>13 Magic Valley or any price increase in the Magic Valley was</p> <p>14 above competitive levels?</p> <p>15 A. No.</p> <p>16 Q. You were also asked some questions to demonstrate</p> <p>17 that, in doing your critical loss analysis, you obtained</p> <p>18 some information from Joni Stright of St. Luke's.</p> <p>19 A. Yes.</p> <p>20 Q. Can you just summarize briefly, what type of</p> <p>21 information did Ms. Stright provide to you that you relied</p> <p>22 on in your critical loss analysis?</p> <p>23 A. She gave me some information on the revenues from</p> <p>24 St. Luke's primary care practices, the cost structures</p> <p>25 broken down by physician so that I could understand the</p>

<p style="text-align: right;">3072</p> <p>1 difference between the fixed costs and the variable costs, 2 which is kind of a complicated process, but that goes into 3 determining the critical loss calculation. 4 Q. And why is it that you felt comfortable relying on 5 the information that Ms. Stright provided you? 6 A. I forget her exact position, but she was certainly 7 in a position to understand what those costs were and to 8 provide me reports generated directly from St. Luke's 9 systems. 10 Q. Now, you were also asked by counsel for the 11 Federal Trade Commission about the fact that, on this theme 12 of "Micron is different," that Micron had the Family Health 13 Center in Boise. Do you recall that? 14 A. Yes. 15 Q. Did the Micron -- wasn't the Micron Family Health 16 Center in existence before Micron implemented its new plan? 17 A. Yes, it was. And I believe Saint Al's staffed it. 18 Q. So of what significance in the antitrust analysis 19 or your reliance on Micron is the fact that the Family 20 Health Center exists in Boise? 21 A. It had no significance. 22 Q. And the -- strike that. 23 Counsel for the hospital plaintiffs began by asking you 24 about Nancy Powell's testimony and referring to the fact 25 that Scott Clement testified that he thought Regence needed</p>	<p style="text-align: right;">3073</p> <p>1 to have Saltzer in its network. Do you recall that? 2 A. I do. 3 Q. So that must mean that, if Regence felt like it 4 had to have Saltzer in the network, Saltzer must have market 5 power? Is that the way we should understand it? 6 A. No. 7 Q. Why not? 8 A. As I have mentioned before, the health plans 9 compete by constructing alternative types of networks. This 10 is how they market their products to the variety of 11 consumers in the Treasure Valley, the different preferences 12 and desires and so forth. 13 Some employers are going to be more interested in 14 a lower cost, maybe narrower network if they think their 15 employees will find that agreeable. Others are happier to 16 have a broad network. 17 And it's clear from -- certainly from the Micron 18 example, that Saltzer needn't be or St. Luke's needn't be in 19 the network, and there would be customers out there who are 20 willing to accept that. 21 Q. You were also asked a question or I suppose 22 impeached with a statement you gave at your deposition about 23 the scope of the merger guidelines and whether they're 24 applicable to physician transactions. And so I want to read 25 the complete testimony and ask whether this is, in fact,</p>
<p style="text-align: right;">3074</p> <p>1 your testimony and you agree with it. 2 Question: "Are there any particular areas of the 3 merger guidelines that you think are off base with regard to 4 physician mergers?" 5 Answer: "I think that there's some that I've 6 identified in this report, in my analysis, with regard to 7 this particular transaction. I don't know that they're 8 applicable -- my critiques of the merger guidelines are 9 applicable in every transaction." 10 Was that your testimony? 11 A. Yes. 12 Q. Plaintiffs' counsel also referred in 13 cross-examination to the slide that you had that showed 14 changes in HHIs using Micron as an example; is that right? 15 A. That's right. 16 Q. Are you proposing that Micron be treated as a 17 separate market? 18 A. Not at all. It was just an illustration. 19 Q. Are the takeaways that you draw just from that 20 illustration, would they be different if you changed Micron 21 to, you know, Nampa market or some other defined geographic 22 market? 23 A. No. As I testified, the key part there is that 24 with two competitive systems, the size of the two systems, 25 as long as they're adequate alternatives, should guarantee</p>	<p style="text-align: right;">3075</p> <p>1 that the payors get competitive prices. 2 Q. If the St. Luke's-Saltzer transaction is allowed 3 to proceed, would any payor be in a position of having to 4 sell a network without having any primary care doctors in 5 Nampa? 6 A. No. 7 Q. Why is that? 8 A. Because the SAMG physicians are in Nampa, and 9 there are Primary Health physicians in Nampa, and I think 10 there are a few additional primary care physicians in Nampa. 11 Q. And with regard to your definition of foreclosure, 12 when you say that anticompetitive foreclosure can result 13 when a transaction diminishes substantially the competitive 14 constraint of a competitor, does that mean that, for 15 example, if Saint Al's is harmed because there is some loss 16 of referrals or Treasure Valley hospitals, that that's a 17 sufficient basis on which to find the transaction 18 anticompetitive? 19 A. No. 20 Q. What more would you need? 21 A. You need to know whether as a result of this 22 foreclosure, the -- the remaining entity, the St. Luke's and 23 Saint Al -- I'm sorry -- the St. Luke's and Saltzer can 24 raise prices above competitive levels. If all that happens 25 is that one provider loses some sales, the other provider</p>

<p style="text-align: right;">3076</p> <p>1 loses some sales, but at the end of the day, Saint Al's is</p> <p>2 still a competitive alternative for health plans, then it's</p> <p>3 not going to allow -- it's going to prevent St. Luke's from</p> <p>4 being able to increase prices above competitive levels, and</p> <p>5 there would be no competitive harm.</p> <p>6 MR. STEIN: Your Honor, I have no further</p> <p>7 questions.</p> <p>8 THE COURT: Recross.</p> <p>9 MR. HERRICK: Very briefly, Your Honor.</p> <p>10 THE COURT: Yes.</p> <p>11 RE CROSS-EXAMINATION</p> <p>12 BY MR. HERRICK:</p> <p>13 Q. Dr. Argue, I believe during your redirect</p> <p>14 testimony, you testified that St. Luke's integration is just</p> <p>15 starting up. Did I understand your testimony correctly?</p> <p>16 A. I think that's the terminology I used.</p> <p>17 Q. How far back did St. Luke's start acquiring</p> <p>18 physicians?</p> <p>19 A. I think it was maybe 2007.</p> <p>20 Q. And just to clarify, Mr. Stein asked you about</p> <p>21 risk-based contracting. You can't say yes or no whether</p> <p>22 risk-based contracting is a merger-specific benefit of this</p> <p>23 transaction; correct?</p> <p>24 A. I think I can say that with regard to Saltzer.</p> <p>25 THE COURT: Let me inquire on that issue.</p>	<p style="text-align: right;">3077</p> <p>1 What I understood your testimony to be is that</p> <p>2 St. Luke's can -- probably has the size and the resources</p> <p>3 and the momentum to move to risk-based contracting, but that</p> <p>4 Saltzer does not?</p> <p>5 THE WITNESS: I'm probably overstating it, and I'm</p> <p>6 sure Mr. Herrick will bring up a clip to show me.</p> <p>7 There are different types of risk-based contracting,</p> <p>8 value-based contracting. St. Luke's has the capability</p> <p>9 certainly to gain -- to do contracting that's going to</p> <p>10 reward them for quality improvements or something along</p> <p>11 those lines. But it can carry it further because of its</p> <p>12 size, because of the nature of the scope of services, the</p> <p>13 sheer volume over which it has to spread that risk. If</p> <p>14 there is a big financial hit, St. Luke's is going to take it</p> <p>15 on the chin rather than the health insurance plan when you</p> <p>16 get into a full-risk contract.</p> <p>17 Saltzer doesn't have the resources to take on full-risk</p> <p>18 contracting. Yes, it can take on other kinds of value-based</p> <p>19 contracting in terms of a contract that will reward them for</p> <p>20 reducing costs or reward them for improving quality. But as</p> <p>21 I said yesterday, that's -- that's kind of the baby steps</p> <p>22 for integration.</p> <p>23 What's really the goal of St. Luke's is to get to the</p> <p>24 full-risk contracting where the provider is taking on all</p> <p>25 the -- all the -- you know, if the cost goes up, it's on the</p>
<p style="text-align: right;">3078</p> <p>1 provider. If the quality goes down, it's on the provider.</p> <p>2 Taking that off the insurance company, that's what</p> <p>3 changes the financial incentive and makes the provider much</p> <p>4 more concerned about what they're doing.</p> <p>5 MR. HERRICK: Your Honor, if I may reask the</p> <p>6 question.</p> <p>7 BY MR. HERRICK:</p> <p>8 Q. Dr. Argue, you can't say, yes or no, whether</p> <p>9 risk-based contracting is a merger-specific benefit of this</p> <p>10 transaction; correct?</p> <p>11 A. I think that's correct, at least in the context of</p> <p>12 full risk-based contracting.</p> <p>13 MR. HERRICK: I have no further questions.</p> <p>14 THE COURT: Mr. Ettinger.</p> <p>15 MR. ETTINGER: No questions, Your Honor.</p> <p>16 THE COURT: Any re-redirect?</p> <p>17 MR. STEIN: No further questions.</p> <p>18 THE COURT: All right. You may step down. Thank</p> <p>19 you.</p> <p>20 St. Luke's may call its next witness.</p> <p>21 MR. STEIN: Thank you, Your Honor. I think</p> <p>22 consistent with what we have done with other experts in</p> <p>23 terms of exhibits to Dr. Argue's report, we'll make a</p> <p>24 proposal to plaintiffs' counsel to see if we can reach some</p> <p>25 agreement on which exhibits to his report which are on our</p>	<p style="text-align: right;">3079</p> <p>1 exhibit list we'll move into evidence.</p> <p>2 THE COURT: All right.</p> <p>3 MR. STEIN: There were a number of exhibits to his</p> <p>4 report that he testified about. There were some exhibits to</p> <p>5 his report that he didn't testify about. But I think, as we</p> <p>6 have done, we'll try to work something out.</p> <p>7 THE COURT: That would certainly be appreciated.</p> <p>8 MR. STEIN: Our next witness is William Savage.</p> <p>9 THE COURT: Yes.</p> <p>10 MR. HERRICK: Your Honor, just a housekeeping</p> <p>11 matter, would you like to us publish Dr. Argue's deposition</p> <p>12 now?</p> <p>13 THE COURT: Yes. Let's go ahead and do that while</p> <p>14 we're bringing in Dr. Savage. Do you have the original?</p> <p>15 MR. HERRICK: We do.</p> <p>16 THE COURT: Ms. Gearhart, if you'll publish</p> <p>17 Dr. Argue's deposition.</p> <p>18 THE CLERK: The deposition of David Argue taken</p> <p>19 August 28th, 2013, is published.</p> <p>20 THE COURT: Dr. Savage, would you please step</p> <p>21 before Ms. Gearhart and be sworn.</p> <p>22 WILLIAM EARL SAVAGE,</p> <p>23 having been first duly sworn to tell the whole truth,</p> <p>24 testified as follows:</p> <p>25 THE CLERK: Please state your complete name and</p>

<p style="text-align: right;">3080</p> <p>1 spell your name for the record.</p> <p>2 THE WITNESS: William Earl Savage. W-I-L-L-I-A-M,</p> <p>3 Earl, E-A-R-L, Savage, S-A-V-A-G-E.</p> <p>4 THE COURT: You may inquire, Mr. Keith.</p> <p>5 MR. KEITH: Thank you, Your Honor.</p> <p>6 DIRECT EXAMINATION</p> <p>7 BY MR. KEITH:</p> <p>8 Q. Mr. Savage, who is your current employer?</p> <p>9 A. St. Luke's Health System.</p> <p>10 Q. And what is your title?</p> <p>11 A. I'm a director.</p> <p>12 Q. And what are your responsibilities as director of</p> <p>13 St. Luke's Health System?</p> <p>14 A. I have an operational responsibility for Saltzer</p> <p>15 Medical Group.</p> <p>16 Q. And where were you employed prior to joining</p> <p>17 St. Luke's Health System?</p> <p>18 A. Saltzer Medical Group.</p> <p>19 Q. What title did you have there?</p> <p>20 A. CEO.</p> <p>21 Q. And generally speaking, what were your</p> <p>22 responsibilities as CEO of Saltzer?</p> <p>23 A. Direct operational and financial responsibility</p> <p>24 for Saltzer.</p> <p>25 THE COURT: Could you bring the microphone just a</p>	<p style="text-align: right;">3081</p> <p>1 little bit closer? Thank you.</p> <p>2 BY MR. KEITH:</p> <p>3 Q. So could you explain to the court or compare your</p> <p>4 responsibilities today as a director of St. Luke's Health</p> <p>5 System to your responsibilities as CEO of Saltzer.</p> <p>6 A. They're very much the same. The same departments</p> <p>7 and managers all still report to me. I don't have sole</p> <p>8 financial responsibility; although, I do have budget</p> <p>9 responsibility.</p> <p>10 Q. And were you involved in the process that led up</p> <p>11 to the transaction between St. Luke's and Saltzer that's the</p> <p>12 subject of this lawsuit?</p> <p>13 A. Yes, I was.</p> <p>14 Q. And to your knowledge, were you involved from the</p> <p>15 beginning of that process?</p> <p>16 A. As far as I know.</p> <p>17 Q. The court has heard a fair amount of testimony</p> <p>18 about the reasons each side came to the transaction. I have</p> <p>19 a much narrower question and it is: Who approached whom</p> <p>20 first?</p> <p>21 A. We approached -- we approached St. Luke's in the</p> <p>22 beginning.</p> <p>23 Q. Turning to a different subject. In terms of how</p> <p>24 the compensation for the -- for Saltzer was set under the</p> <p>25 agreement with St. Luke's, did the volume or revenue</p>
<p style="text-align: right;">3082</p> <p>1 generated by Saltzer for its ancillary services -- like</p> <p>2 laboratory, imaging, physical therapy, that kind of thing --</p> <p>3 factor into what Saltzer gets paid under the agreement?</p> <p>4 A. No, it doesn't.</p> <p>5 Q. And did anyone during the process of negotiations</p> <p>6 suggest to you or to Saltzer generally that the volume or</p> <p>7 revenue of ancillary services that Saltzer physicians</p> <p>8 ordered during the five-year term of the agreement would</p> <p>9 impact negotiations in terms of compensation for any</p> <p>10 following agreement after the five-year term?</p> <p>11 A. No. That was never discussed.</p> <p>12 Q. Did anyone suggest to you during -- did anyone</p> <p>13 suggest to Saltzer that the treatment of unpaid or</p> <p>14 low-paying patients such as Medicaid during the term of the</p> <p>15 five-year agreement would impact compensation in any</p> <p>16 subsequent agreement negotiated between the parties?</p> <p>17 A. No. Never.</p> <p>18 Q. And does the agreement have a provision that</p> <p>19 addresses that issue?</p> <p>20 A. Yes. We are -- we are paid the same regardless of</p> <p>21 which patients we see.</p> <p>22 Q. And to your knowledge, has Saltzer seen</p> <p>23 substantially more Medicaid and low-paying patients?</p> <p>24 A. Yes. In my observation, I have seen what I</p> <p>25 believe to be a significant increase in patient numbers.</p>	<p style="text-align: right;">3083</p> <p>1 Q. Turning to a different subject, the court will</p> <p>2 hear testimony tomorrow from an expert, one of the</p> <p>3 defendants' experts, about the impact on compensation for</p> <p>4 Saltzer physicians should the court unwind the transaction</p> <p>5 as a result of the loss of physicians relative to fiscal</p> <p>6 year 2012. So I'm not going to ask you about that</p> <p>7 specifically.</p> <p>8 But plaintiffs have also made -- plaintiffs' expert has</p> <p>9 raised a number of ways that he believes Saltzer can resolve</p> <p>10 this problem, and I wanted to ask you about those proposals</p> <p>11 and whether they're realistic.</p> <p>12 So my first question is: What's the greatest number of</p> <p>13 surgeons that Saltzer has successfully recruited in any</p> <p>14 two-year period?</p> <p>15 A. Two would be the -- would be the most in a</p> <p>16 two-year period. We haven't recruited more than one in the</p> <p>17 last -- per year in the last ten years.</p> <p>18 Q. And other than the recent departures, over the</p> <p>19 last ten-year period, what's the greatest number of</p> <p>20 physicians that Saltzer has lost in any one year?</p> <p>21 A. I think two, maybe four in one year.</p> <p>22 Q. And in that year or years when those four</p> <p>23 physicians were lost, were any of them the -- the highest</p> <p>24 producing physicians of Saltzer?</p> <p>25 A. No. Many of them, as I look back, they -- many of</p>

3084

3085

1 them were new physicians. You don't always make a perfect
2 match. And they were lower -- low producing or
3 underproducing and weren't happy and left. And so they were
4 underperforming. Some of them, of course, were retirements
5 and normal attrition.

6 **Q.** What are the positions that Saltzer is currently
7 recruiting to fill, physician specialties and the like?

8 **A.** Oh, let's see if I can remember. Orthopedics --
9 orthopedics and OB, dermatology, and pediatrics.

10 **Q.** And how many orthopedic positions is Saltzer
11 looking to fill?

12 **A.** We -- we have three that we're looking to fill.

13 **Q.** And that's less than the number of orthopedic
14 physicians who left the practice; is that correct?

15 **A.** Yes.

16 **Q.** And why is Saltzer looking to fill fewer than --
17 fewer spots than are vacant after the departure of the
18 physicians to Saint Alphonsus?

19 **A.** Those physicians are -- that departed are still in
20 the market. We're not sure, you know, how many we'll be
21 able to keep busy. I think three is kind of a minimum
22 number for call and coverage.

23 **Q.** And plaintiffs have suggested that Saltzer should
24 have no problem recruiting specialists like the orthopedists
25 because there is a built-in referral base from the primary

1 care physicians at Saltzer. Do you have a response to that
2 argument?

3 **A.** Yes. Saltzer wouldn't be able to and hadn't been
4 able to on its own recruit, particularly specialists. The
5 guarantees -- the demands for these physicians is very high.
6 Guarantees have shot up, and the monies you have to pay to
7 get them recruited are significant.

8 **Q.** And what was the -- what portion of the business
9 of the orthopedic surgeons who left Saltzer was comprised of
10 internal referrals versus referrals from physicians who were
11 outside of Saltzer?

12 **A.** It ranged. You know --

13 MR. ETTINGER: Your Honor, I object to lack of
14 foundation. We haven't seen the witness has a basis for
15 coming up with a number.

16 THE COURT: I was thinking somewhat the same
17 thing.

18 MR. KEITH: Sure. I'll try to establish that.
19 BY MR. KEITH:

20 **Q.** As CEO of the Saltzer Medical Group, Mr. Savage,
21 was it your responsibility to understand where referrals
22 were coming from for your orthopedic surgeons?

23 **A.** Yeah. The orthopedists and other specialists who
24 rely on referrals, at different times we would look into
25 those numbers at their request, generally. It's part of

3086

3087

1 practice management.

2 MR. KEITH: I believe, Your Honor, that's the
3 foundation. I don't know if there is an objection to that.

4 THE COURT: Well, I guess I want to know how. I
5 mean, was there a specific number generated by Saltzer to
6 differentiate between referrals from outside PCPs versus
7 in-house PCPs?

8 BY MR. KEITH:

9 **Q.** So how did you go about analyzing the source of
10 referrals for the specialists of Saltzer?

11 **A.** You go back and look at their daily schedules.
12 New patients referred into the clinics are -- are
13 identified -- actually, all new patients are identified as
14 to who they're referred by. So if it was referred by one of
15 my family practice doctors, it would have his name by that.
16 If it wasn't, it would have another name. It might even
17 have self-referral if somebody -- orthopedics, sometimes
18 people walk into the clinics on their own.

19 **Q.** So you would review those schedules to determine
20 what portion, roughly, of referrals came from internal --
21 physicians internal to Saltzer versus outside physicians?

22 **A.** Yes.

23 **Q.** And based on that -- that analysis, what portion
24 of the total business of the orthopedic surgeons of Saltzer
25 came from internal sources versus external referrals?

1 **A.** Across the different specialties, the range would
2 be from 30 to 50 percent of their referrals would come from
3 outside of the clinic, of Saltzer's primary care physicians,
4 usually.

5 THE COURT: Just a moment. You talked about
6 across different specialties. Are you talking about
7 subspecialties within orthopedics?

8 THE WITNESS: Yes, sir.

9 THE COURT: Okay.

10 THE WITNESS: So we had -- we had sports, spine,
11 hand, joint, and a fifth one that I don't remember right
12 now.

13 BY MR. KEITH:

14 **Q.** So would a physician -- an orthopedic physician
15 who joined Saltzer, in your mind, be able to rely
16 exclusively on internal referrals to build a practice?

17 **A.** It would be very slow. So that's one of the
18 reason we sized -- we feel that we right-sized the
19 recruitment at this time.

20 **Q.** And let's talk more about recruiting. Have you
21 run into any difficulties recruiting physicians to the
22 Saltzer Medical Group?

23 MR. ETTINGER: Your Honor, could we have a --
24 object as to form. It would be interesting to know what
25 time period the question applies to.

<p style="text-align: right;">3088</p> <p>1 MR. KEITH: Sure.</p> <p>2 MR. ETTINGER: And what specialty.</p> <p>3 BY MR. KEITH:</p> <p>4 Q. In recruiting orthopedic surgeons over the past</p> <p>5 six or eight months, have you run into any problems in</p> <p>6 successfully recruiting physicians to the Saltzer Medical</p> <p>7 Group?</p> <p>8 A. We have talked to a number of physicians in</p> <p>9 orthopedics. There is not many, but we have had success in</p> <p>10 speaking with some. I haven't got anyone signed yet.</p> <p>11 Q. And have any of the recruits that you have spoken</p> <p>12 to expressed reservations about the potential outcome of</p> <p>13 this lawsuit?</p> <p>14 A. Yes. And --</p> <p>15 MR. ETTINGER: Your Honor, I think we're into</p> <p>16 hearsay here.</p> <p>17 THE COURT: Sustained.</p> <p>18 BY MR. KEITH:</p> <p>19 Q. Mr. Savage, do you have a view as to whether</p> <p>20 Saltzer will be capable of recruiting sufficient numbers of</p> <p>21 physicians to fill the empty spots to address the loss of</p> <p>22 physicians that Saltzer has faced if the Saltzer Medical</p> <p>23 Group is unwound?</p> <p>24 A. I do. I think it would be very difficult to</p> <p>25 recruit them into an independent, freestanding group.</p>	<p style="text-align: right;">3089</p> <p>1 Physicians are -- today, everyone we're recruiting is coming</p> <p>2 out of fellowship or residency. They're all very attuned to</p> <p>3 the current state of healthcare, and they are looking for</p> <p>4 systems, and that's very important to them.</p> <p>5 Q. Plaintiffs have -- plaintiffs' expert has argued</p> <p>6 that Saltzer can substantially address the overhead problems</p> <p>7 resulting from the loss of physicians relative to fiscal</p> <p>8 year 2012 by selling off, leasing, or consolidating certain</p> <p>9 of its facilities. I wanted to ask you some particular</p> <p>10 questions about that.</p> <p>11 Are there -- did the departure of physicians relative</p> <p>12 to fiscal year 2012 leave any spaces in any of the Saltzer</p> <p>13 facilities that could be sold or leased to reduce overhead?</p> <p>14 A. As a multispecialty clinic, we don't -- we don't</p> <p>15 build single clinics for a specialty. So our main clinic in</p> <p>16 the -- in Nampa is -- is a multispecialty clinic. I</p> <p>17 can't -- I can't carve out a single piece easily.</p> <p>18 Our -- in Meridian, we have approximately 20,000</p> <p>19 square feet. It's one big practice. And there is no -- no</p> <p>20 separate -- you know, no separate entrance or a way I could</p> <p>21 carve off the area that was used for dermatology and</p> <p>22 orthopedics and ENT that all went over there.</p> <p>23 Q. What about the Ventana property?</p> <p>24 A. Ventana property is much the same, particularly</p> <p>25 the orthopedic clinic that we have there is not used to a</p>
<p style="text-align: right;">3090</p> <p>1 great extent right now. It's all part of -- with physical</p> <p>2 therapy. It's an open -- it's an open plan. Basically, the</p> <p>3 orthopedic department and physical therapy are as one. And</p> <p>4 it's -- it would be all but impossible to rebuild the clinic</p> <p>5 so that you could carve off that space.</p> <p>6 Q. And I should have asked this. But the Ventana</p> <p>7 property is where?</p> <p>8 A. It's in Northwest Nampa. Many people use the --</p> <p>9 it seems everybody knows where Costco is, so it's just north</p> <p>10 of Costco.</p> <p>11 Q. Plaintiffs' expert also made the suggestion that</p> <p>12 Saltzer could move its billing department from its current</p> <p>13 location, which is on Georgia Avenue in Nampa, into the main</p> <p>14 clinic on Hawaii Avenue.</p> <p>15 Do you have a response to that suggestion?</p> <p>16 A. Yeah. I don't have enough space in -- in the</p> <p>17 clinic we're recruiting for these positions, I don't have</p> <p>18 enough space in the clinic to house our full billing and</p> <p>19 collections and coding department.</p> <p>20 Q. And would the space that's now available in the</p> <p>21 Hawaii Avenue location be appropriate for billing personnel?</p> <p>22 A. It's -- it's all clinical space, so it would</p> <p>23 require an investment in remodeling, tearing out -- you</p> <p>24 know, nurses' stations and small exam rooms don't lend</p> <p>25 itself to -- to billing and collection clerks.</p>	<p style="text-align: right;">3091</p> <p>1 Q. What about the possibility of consolidating</p> <p>2 multiple of these offices into some third location not yet</p> <p>3 occupied by Saltzer? Could that be done?</p> <p>4 A. Well, they are satellites. They are in Meridian</p> <p>5 because we have a -- there is not enough room to consolidate</p> <p>6 them. We have put them into a single -- a single clinic.</p> <p>7 You know, I have them located in different places.</p> <p>8 Q. And would there be a building that you're aware of</p> <p>9 in Nampa to which you could move all of that -- all of those</p> <p>10 personnel?</p> <p>11 A. No. We would have to -- I believe we'd have to</p> <p>12 build it. We have 78,000 square feet in our building on</p> <p>13 Hawaii Avenue.</p> <p>14 Q. Plaintiffs' expert has also suggested that Saltzer</p> <p>15 could simply trim the fat. Do you have a response to that?</p> <p>16 A. I don't think there is a lot of fat to trim. I</p> <p>17 have a number of -- as a physician-run -- in the past,</p> <p>18 physician-run medical group, we had very -- we work very</p> <p>19 hard to keep our expenses down. We think we were highly</p> <p>20 efficient, and I don't think there is sufficient -- I would</p> <p>21 have cut it by now. There is no reason not to cut it.</p> <p>22 Q. What about laying off midlevel providers? Is that</p> <p>23 an option that would address the overhead problem?</p> <p>24 A. Midlevel providers are revenue producers, and they</p> <p>25 are all very productive and they -- they see overflow. Some</p>

3092

3093

1 of them have patients of their own. And to -- to terminate
2 them, I would lose -- I would lose a revenue that we make
3 from those doctors.

4 **Q.** What about the suggestion that the Saltzer
5 physicians could simply work harder? Is that a realistic
6 possibility for addressing the overhead problem?

7 **A.** Our doctors have always been paid on productivity.
8 And they are highly -- they are highly motivated to -- to
9 see as many patients and work as -- work as hard as
10 possible.

11 I don't think I have a lot of excess capacity
12 anywhere except maybe in one or two new physicians that have
13 been there a year or so still building.

14 **Q.** Plaintiffs' expert also suggests that there are
15 equipment leases that are -- have run out or soon to run out
16 that would alleviate some of the overhead problem. Do you
17 have a response to that?

18 **A.** I believe the two that he was talking about
19 have -- have to do with our Advanced Imaging Center, MR,
20 MRI, and CT. Both of those, they were five-year leases.
21 They have been paid off. The software and even some of the
22 physical aspects of those have to be -- have to be upgraded
23 now at this time in order to maintain them so we can still
24 get them serviced by Siemens.

25 **Q.** And does the state of the advanced imaging

1 equipment at Saltzer impact your ability to recruit
2 physicians?

3 **A.** Yeah. You want to have -- you want to have the
4 most current imaging possible. You want it to measure up to
5 the -- to the other options in the market. And so it
6 doesn't -- it doesn't do to let you run behind in technology
7 and have less-than-adequate imaging.

8 **Q.** What about the suggestion that Saltzer could
9 simply suspend payments into its physicians' and employees'
10 retirement accounts? Do you view that as a realistic option
11 for addressing the overhead problem?

12 **A.** To completely take that away, we're going to
13 have -- that's very important not only to physicians but to
14 employees. And if we pulled the employees back into
15 Saltzer, cut their salaries back to the levels that we were
16 paying them and then cut or eliminate the retirement, it
17 would be -- would be very difficult.

18 This would compound my recruitment problem.
19 Everyone -- every doctor that we talk to, they are very
20 astute, and they are looking for what kind of a retirement
21 program do you have within your group.

22 And then my existing physicians that are there,
23 to, you know, cut -- to see the cutback that they're going
24 to lose 30 percent or a significant amount from what they
25 were making and then to cut their ability to put some of

3094

3095

1 that into retirement is -- is going to be a disincentive.

2 **Q.** Are any of the Saltzer physicians under a -- an
3 agreement, a noncompetition agreement or other agreement,
4 that would prevent them from leaving Saltzer Medical Group
5 in the event of an unwind and practicing across the street
6 or in the same area?

7 **A.** I have two physicians who still have a noncompete.
8 They are very new. One is a pediatrician, and the other one
9 is a rheumatologist.

10 **Q.** And the other physicians, would they be free to
11 practice --

12 **A.** Yes.

13 **Q.** -- and compete against Saltzer Medical Group?

14 **A.** Yes, they would.

15 **Q.** Plaintiffs have suggested that Saltzer has a --
16 that Saltzer will be able to weather the problems with
17 overhead because there are -- there is \$9 million of money
18 that St. Luke's paid as part of the transaction that may not
19 need to be repaid if the court ultimately decides this
20 transaction should be unwound.

21 Do you have an understanding of what they -- what
22 they're referring to in terms of the \$9 million?

23 **A.** \$6 million of -- well, \$6 million was paid out in
24 goodwill. I believe the \$9 million has to do with -- so I
25 think it's goodwill and workforce in place.

1 **Q.** And the \$6 million in goodwill payments, to whom
2 were those payments made?

3 **A.** Those were made directly by -- by written
4 agreement, directly to the physicians. They own their
5 goodwill.

6 **Q.** So that money, did it ever touch the Saltzer bank
7 accounts?

8 **A.** No, we never -- we never touched that money.

9 **Q.** And how much was paid in workforce in place?

10 **A.** \$3.3 million.

11 **Q.** Were there any obligations that Saltzer had to
12 fund out of that workforce-in-place pot of money that
13 reduced what Saltzer has remaining?

14 **A.** Yeah. We had significant liabilities. Primarily
15 we had to pay back ESL -- that's extended sick leave -- of
16 \$250,000; approximately \$270,000 in PTO; that was taken with
17 our employees over to the -- over to St. Luke's. So we --
18 Luke's assumed that liability. We paid them for that, that
19 liability.

20 And then -- and then we also had to pay retirement
21 out of that. We had a -- we had a retirement liability was
22 done.

23 **Q.** So the -- was there also a payment to some of the
24 physicians who didn't receive goodwill payments directly
25 from St. Luke's?

3096

1 **A.** There were -- it -- included in that \$3.3 million,
2 there was -- there were three doctors who had at that time
3 who had -- who had noncompetes in place. And there was
4 2.7 -- \$270,000, something like that, that went to them.
5 **Q.** I believe you said earlier that the amount paid to
6 St. Luke's in terms of paid time off was \$270,000, and you
7 just said there was \$270,000 in payments to the three
8 physicians.
9 Are those -- are you perhaps confusing two of the
10 payments that were made?
11 **A.** Yes, but I'm -- I'm not getting the numbers
12 straight right now.
13 **Q.** In terms of paid time off, what's your best
14 recollection of the amount that Saltzer had to pay to
15 St. Luke's in total for that -- that amount?
16 **A.** I don't remember exactly. I'm sorry. If you show
17 me the documents, I could, but I don't have it.
18 **Q.** If I told you it was \$350,000, would that sound
19 right?
20 MR. ETTINGER: Your Honor, pretty leading.
21 THE COURT: Yeah, that may be -- set the gold
22 standard for leading.
23 (Laughter.)
24 THE COURT: Something to aspire to, I guess.
25 MR. KEITH: I think we can get there another

3098

1 Basically, we zero out, we like to call it, at the end of
2 the year. Everything gets -- or it will get taxed within
3 the corporation. So we distribute everything to
4 shareholders and physicians.
5 **Q.** Put differently, if Saltzer had retained close to
6 \$2 million in its own bank accounts, what -- what would have
7 been the consequences for the tax liability for the
8 corporation and the shareholders?
9 **A.** Between federal and state, it would have been
10 approximately 42 -- 40, 42 percent taxes.
11 **Q.** At the corporation level?
12 **A.** Yes.
13 **Q.** And then what would happen then if that money was
14 distributed to the individual shareholders thereafter?
15 **A.** Later, they would be taxed again.
16 **Q.** So I want to see if we can compare, then, what
17 you've said about the current state of the finances of
18 Saltzer and its condition with where it would have been in
19 December of 2012 had the court unwound -- enjoined the
20 transaction at that time.
21 Let's start with December 2012. If the court had
22 enjoined the transaction at that point, would Saltzer have
23 faced the same problems with overhead that it -- that it
24 faces today?
25 MR. ETTINGER: Objection. Leading.

3097

1 direction, Your Honor.
2 BY MR. KEITH:
3 **Q.** How much of the WIP, workforce in place, payment
4 is left in the Saltzer bank accounts?
5 **A.** Approximately 400,000.
6 **Q.** And you've noted there were obligations that
7 Saltzer had to pay out of the WIP payment. So between the,
8 you say, 3.3 million in WIP payments and the \$400,000 that
9 are left, where did the rest of that money go?
10 **A.** We had a retirement liability of 2.1 million. We
11 had to pay ESL. We had a payroll that was -- that was due.
12 Taxes and -- what does that add up to? I'm sorry.
13 **Q.** Well, was there a share buyback that Saltzer
14 undertook?
15 **A.** Yes. We had \$1.8 million in share buyback.
16 **Q.** And why was that buyback undertaken?
17 **A.** The value of Saltzer shares are based on -- are
18 based on the assets of the group. And we had sold all the
19 assets, and so that money was there. We were obligated
20 to -- to pay it back to them, to reacquire -- the
21 corporation reacquire those shares.
22 **Q.** Would it be standard practice for Saltzer to
23 carry, you know, an amount close to \$2 million in its open
24 accounts?
25 **A.** Yeah. We're a professional corporation.

3099

1 THE COURT: Overruled.
2 THE WITNESS: We would still have to meet a
3 significant overhead with -- with the absence of all of our
4 surgeons.
5 BY MR. KEITH:
6 **Q.** And did Saltzer have funds in its bank accounts
7 not obligated to some other use that it could have utilized
8 to sort of weather the storm at that point?
9 **A.** No, we didn't.
10 **Q.** And compare that to today. If the court decides
11 the transaction should be unwound and Saltzer becomes
12 independent, what is Saltzer's position with respect to the
13 overhead that it would have to absorb relative to December
14 2012?
15 **A.** It would be exactly the same. I do have a -- I
16 have been fortunate enough to recruit a new -- new
17 specialist, an ENT, an otolaryngologist. So I guess we're
18 some better off in that we have one -- one new physician to
19 our group.
20 **Q.** And did St. Luke's assist financially in the
21 recruitment of that ENT?
22 **A.** Oh, absolutely.
23 **Q.** In your view, would Saltzer have been successful
24 in recruiting that ENT had St. Luke's not provided financial
25 assistance?

<p style="text-align: right;">3100</p> <p>1 A. We couldn't have even funded his guarantee let</p> <p>2 alone his comp.</p> <p>3 Q. And in terms of the bank -- the money in the bank</p> <p>4 that Saltzer has today to try to weather the storm, is that</p> <p>5 different, more or less, than what it would have had in</p> <p>6 December 2012?</p> <p>7 A. No. We have very little.</p> <p>8 Q. In both cases?</p> <p>9 A. Yes.</p> <p>10 MR. KEITH: No further questions, Your Honor.</p> <p>11 THE COURT: Mr. Ettinger.</p> <p>12 MR. ETTINGER: I don't know if -- I intend to be a</p> <p>13 while. I don't know if you --</p> <p>14 THE COURT: Yeah. I lost track of the time.</p> <p>15 MR. ETTINGER: My stomach was calling me,</p> <p>16 Your Honor.</p> <p>17 THE COURT: Yeah. It's one of those unusual times</p> <p>18 when mine wasn't. We'll take a 15-minute recess at this</p> <p>19 time.</p> <p>20 (Recess.)</p> <p>21 *****COURTROOM REMAINS OPEN TO THE PUBLIC*****</p> <p>22 THE COURT: Mr. Savage, I'll remind you, you are</p> <p>23 still under oath.</p> <p>24 Mr. Ettinger, you may conduct your cross-examination of</p> <p>25 the witness.</p>	<p style="text-align: right;">3101</p> <p>1 MR. ETTINGER: Thank you, Your Honor.</p> <p>2 CROSS-EXAMINATION</p> <p>3 BY MR. ETTINGER:</p> <p>4 Q. Mr. Savage, if this transaction were unwound,</p> <p>5 there is an agreement that St. Luke's would loan money to</p> <p>6 Saltzer that could be paid back much like a lease; isn't</p> <p>7 that right?</p> <p>8 A. Yes, at fair market value.</p> <p>9 Q. And are there current equipment -- are there</p> <p>10 current operating leases involving assets between Saltzer</p> <p>11 and St. Luke's?</p> <p>12 A. No.</p> <p>13 Q. Let me --</p> <p>14 MR. ETTINGER: Keely, could you pull up JX24. Do</p> <p>15 you have page 14?</p> <p>16 MS. DUKE: I don't have page 14.</p> <p>17 BY MR. ETTINGER:</p> <p>18 Q. Let me just read you some language.</p> <p>19 THE COURT: That's Joint Exhibit 24; correct?</p> <p>20 MR. ETTINGER: Right, right. Well, we do have</p> <p>21 page -- we have page 13 up, but --</p> <p>22 BY MR. ETTINGER:</p> <p>23 Q. Is there -- is there an op- -- let me just ask you</p> <p>24 this, Mr. Savage: Is there an operating lease executed by</p> <p>25 the parties, Saltzer and St. Luke's?</p>
<p style="text-align: right;">3102</p> <p>1 A. Not that I can recall.</p> <p>2 Q. Okay. Now, Saltzer has never developed a plan to</p> <p>3 deal with the possibility of an order that it be unwound</p> <p>4 from St. Luke's; correct?</p> <p>5 A. Yes.</p> <p>6 Q. And, in fact, you have really never thought about</p> <p>7 such a plan, have you?</p> <p>8 A. No, I don't know that's true. You know, doctors</p> <p>9 have mentioned it.</p> <p>10 MR. ETTINGER: Why don't you play, Keely, cross</p> <p>11 clip 11.</p> <p>12 This is Mr. Savage's deposition, Your Honor, at page</p> <p>13 165, lines 14 through 22.</p> <p>14 (Video clip played as follows:)</p> <p>15 Q. "Have you sat down with your colleagues</p> <p>16 and tried to develop a plan B?</p> <p>17 A. "No.</p> <p>18 Q. "Why not?</p> <p>19 A. "I -- I don't know.</p> <p>20 Q. "You never thought about it; is that</p> <p>21 right?</p> <p>22 A. "Not at this juncture."</p> <p>23 (Video clip concluded.)</p> <p>24 BY MR. ETTINGER:</p> <p>25 Q. Now, you -- was that your testimony, Mr. Savage?</p>	<p style="text-align: right;">3103</p> <p>1 A. Oh, yes, it was.</p> <p>2 Q. Now, and your deposition was in June; is that</p> <p>3 right?</p> <p>4 A. I believe so.</p> <p>5 Q. And that was six months after you filed a</p> <p>6 declaration with the court raising the concerns about a</p> <p>7 possible unwind; correct?</p> <p>8 A. Yes.</p> <p>9 Q. Okay. Now, it's difficult to recruit physicians</p> <p>10 to a practice if they don't know who's going to own the</p> <p>11 practice; isn't that right?</p> <p>12 A. Yes.</p> <p>13 Q. And that's certainly true today for Saltzer;</p> <p>14 correct?</p> <p>15 A. Yes.</p> <p>16 Q. You're also aware that if you came into court and</p> <p>17 said, "We have now successfully recruited three orthopedic</p> <p>18 surgeons," that would be hurting the arguments being made by</p> <p>19 Saltzer and St. Luke's in this case; correct?</p> <p>20 A. Possibly.</p> <p>21 Q. You mentioned in response to Mr. Keith's questions</p> <p>22 about trimming the fat. Has Saltzer hired any outside</p> <p>23 consultants or experts on physician practices to see if they</p> <p>24 could suggest ways that you could trim the fat in the event</p> <p>25 that there were an unwind?</p>

3104

1 **A. No, we haven't.**
 2 **Q.** So fair to say you have never sat down, rolled up
 3 your sleeves, and made a serious effort to think about what
 4 could we do to solve whatever problems we might have if
 5 there were an unwind; correct?
 6 **A. Yes.**
 7 **Q.** Now, has -- has Saltzer sought legal advice on the
 8 nature of the remedy that it might seek from the court in
 9 the event of an unwind to make sure that it can operate as a
 10 successful independent entity?
 11 MR. JULIAN: Objection, calls for privilege. It's
 12 an inappropriate question.
 13 MR. ETTINGER: Your Honor, it's a yes-or-no
 14 question. I'm not going to ask for the substance of the
 15 legal advice; I just want to know whether Saltzer has looked
 16 into the issue.
 17 MR. JULIAN: It is still -- the nature of the
 18 question is going to bring up privilege if they sought a
 19 certain type of advice.
 20 THE COURT: Well, I think the -- well, Counsel, I
 21 think -- to me, it does get us into a rather precarious
 22 area. And I'm not sure that it adds anything to the issues
 23 in this case, so I think I'm going to sustain the objection
 24 at this time. Yeah. I think I'll leave it at that. I'll
 25 sustain the objection.

3106

1 **A. I think the -- it's been brought up in our finance**
 2 **committee.**
 3 **Q.** Has there been a substantive discussion of the
 4 issue in your finance committee?
 5 **A. No.**
 6 **Q.** Would recruiting guarantees from St. Luke's help
 7 Saltzer to recruit if it were unwound?
 8 **A. We would have the -- we have the problem of being**
 9 **an independent group still, but we would not have money to**
 10 **support guarantees at that point.**
 11 **Q.** So recruiting guarantees from St. Luke's would
 12 help Saltzer to recruit?
 13 **A. Possibly.**
 14 **Q.** How many doctors of any specialty has Saltzer
 15 recruited in the last four years, say, roughly?
 16 **A. Oh --**
 17 **Q.** Successfully.
 18 **A. I would say four, up to four maybe. One year we**
 19 **merged a practice in with ours, and I think that there was**
 20 **two physicians in addition to several that we had recruited.**
 21 **Q.** Now, you looked at this overhead issue that
 22 Mr. Keith has asked you about, first in 2011; isn't that
 23 right? And "you," meaning Saltzer.
 24 **A. Would you -- I'm not sure what you're -- looked at**
 25 **the overhead issue?**

3105

1 BY MR. ETTINGER:
 2 **Q.** Mr. Savage, have you given any thought to the
 3 kinds of assistance that St. Luke's might be able to provide
 4 Saltzer to help it through an unwind?
 5 **A. No. I'm not sure in the unwind what sort of**
 6 **assistance I would need.**
 7 **Q.** Okay. Has anyone at Saltzer, to your knowledge,
 8 discussed that subject?
 9 **A. Not with me.**
 10 **Q.** So you're not aware of anyone discussing that
 11 subject at Saltzer?
 12 **A. They have not discussed it with me.**
 13 **Q.** Okay. And do you attend meetings of the finance
 14 committee?
 15 **A. Some of them. I don't attend all of them.**
 16 **Q.** Does Saltzer still have a finance committee?
 17 **A. Yes, it does.**
 18 **Q.** And does it still have an executive committee?
 19 **A. Yes, it does.**
 20 **Q.** And do you attend meetings of the executive
 21 committee?
 22 **A. Yes, I do.**
 23 **Q.** And, to your knowledge, have either of those
 24 committees discussed the issue of how to deal with an
 25 unwind?

3107

1 **Q.** Wasn't there a financial analysis done by Kathy
 2 Maggard of what the implications --
 3 **A. Now I understand.**
 4 **Q.** -- for Saltzer would be if the surgeons left in
 5 terms of overhead and compensation?
 6 **A. In 2011 we looked at the -- if the orthopedists**
 7 **left.**
 8 **Q.** Right, right. And so -- and did you share that
 9 result with other people at Saltzer?
 10 **A. I -- I don't recall having -- Dr. Kaiser and Kathy**
 11 **Maggard and myself.**
 12 **Q.** So you saw it, Ms. Maggard saw it, Dr. Kaiser saw
 13 it; correct?
 14 **A. Yes.**
 15 **Q.** And that analysis suggested that there be a
 16 financial implication for Saltzer if the surgeons left and
 17 were not replaced; isn't that right?
 18 **A. Yes.**
 19 **Q.** And after having done that analysis, Saltzer went
 20 ahead and agreed -- well, strike that. Let me back up for a
 21 second. Sorry.
 22 And you did the analysis then because you were aware
 23 that the surgeons were not happy about the St. Luke's deal,
 24 and if it was consummated in the form that was being
 25 discussed, that might cause them to leave; correct?

<p style="text-align: right;">3108</p> <p>1 A. Yes.</p> <p>2 Q. And, nevertheless, having done that analysis, you</p> <p>3 went forward and consummated a deal with St. Luke's that was</p> <p>4 unacceptable to the surgeons; correct?</p> <p>5 A. There were --</p> <p>6 Q. Is that correct?</p> <p>7 A. Yes.</p> <p>8 Q. And you knew it was going to be unacceptable to</p> <p>9 the surgeons, didn't you?</p> <p>10 A. I didn't know that it was.</p> <p>11 Q. You fully expected that it would be, did you not?</p> <p>12 A. I knew they had concerns.</p> <p>13 Q. And you expected their concerns would rise to the</p> <p>14 level of them leaving if that deal went forward; isn't that</p> <p>15 right?</p> <p>16 A. That was a possibility.</p> <p>17 Q. You thought it was a likelihood, didn't you?</p> <p>18 A. I don't know how likely I thought that it was.</p> <p>19 Q. Okay. And so, nevertheless, despite your</p> <p>20 expectations, despite having done this financial analysis,</p> <p>21 Saltzer went forward with the transaction; correct?</p> <p>22 A. We're a group of --</p> <p>23 Q. Is that correct, Doctor, Mr. Savage?</p> <p>24 A. The shareholders voted to go forward with the</p> <p>25 transaction, sir.</p>	<p style="text-align: right;">3109</p> <p>1 Q. Did anybody recommend to the shareholders, you</p> <p>2 know, there is a precarious financial issue here and we may</p> <p>3 want to reconsider doing this deal in light of that?</p> <p>4 A. I don't know.</p> <p>5 Q. You don't recall ever having said that yourself;</p> <p>6 correct?</p> <p>7 A. It was a vote of the shareholders.</p> <p>8 Q. My question is --</p> <p>9 A. Did I say what? Would you repeat that, please.</p> <p>10 Q. Did you ever say in substance to the shareholders,</p> <p>11 or did anyone else say in substance to the shareholders:</p> <p>12 You know, we have done this financial analysis. We're going</p> <p>13 to take a hit if the surgeons leave, and it looks like</p> <p>14 they'll leave if we do this deal, so maybe we shouldn't do</p> <p>15 this deal?</p> <p>16 A. I think they --</p> <p>17 Q. My question is --</p> <p>18 A. -- thought the benefits were greater than --</p> <p>19 Q. -- did you or anyone else say that --</p> <p>20 (Simultaneous discussion.)</p> <p>21 THE COURT: Let's let the witness finish his</p> <p>22 response.</p> <p>23 MR. ETTINGER: Sorry, Your Honor.</p> <p>24 THE WITNESS: The shareholders voted the benefit</p> <p>25 they had to -- they had to outweigh the cost of five -- of</p>
<p style="text-align: right;">3110</p> <p>1 five -- actually, it was only four shareholders in that</p> <p>2 group, basically running the group and ruling what was good</p> <p>3 for it. We ruled by majority, not by, you know, what</p> <p>4 happens to a few doctors. And we made a number of</p> <p>5 concessions to them in order for them to -- to try and</p> <p>6 address some of their concerns. It seems like every time we</p> <p>7 would address one, another one would come up.</p> <p>8 BY MR. ETTINGER:</p> <p>9 Q. Mr. Savage, my question is the following, and it's</p> <p>10 a very specific question.</p> <p>11 A. Okay.</p> <p>12 Q. If you don't understand it, please let me know.</p> <p>13 Did you or anyone else suggest to the shareholders that</p> <p>14 they ought to carefully consider whether the deal should be</p> <p>15 put off or changed in order to avoid the surgeons leaving</p> <p>16 because of the financial implications of their leaving?</p> <p>17 A. The shareholders knew the consequences.</p> <p>18 Q. My question is: Did you or anyone else that you</p> <p>19 can recall make -- suggest that the deal ought to be changed</p> <p>20 or put off because of the financial implications of the</p> <p>21 surgeons leaving? Yes or no.</p> <p>22 A. I can only speak for myself. No.</p> <p>23 Q. Did you hear anyone else make that suggestion?</p> <p>24 A. I don't recall.</p> <p>25 MR. ETTINGER: Thank you very much.</p>	<p style="text-align: right;">3111</p> <p>1 MR. WILSON: Your Honor, if I may.</p> <p>2 THE COURT: Mr. Wilson.</p> <p>3 MR. WILSON: Your Honor, I intentionally did not</p> <p>4 raise an objection during Mr. Keith's questioning because I</p> <p>5 knew how Your Honor would rule, and I didn't want to</p> <p>6 interrupt the questioning.</p> <p>7 But I would like to renew the State of Idaho's</p> <p>8 objection at this point in time to the testimony that's been</p> <p>9 presented regarding Saltzer's financial condition. I heard</p> <p>10 you loud and clear, Your Honor, when you said to me that I</p> <p>11 should rest easy in that regard.</p> <p>12 Our discussion the other day, however, centered on the</p> <p>13 representations made by Mr. Bierig to the court at the</p> <p>14 injunction hearing and the representations made by</p> <p>15 St. Luke's counsel in connection with a telephonic status</p> <p>16 conference in the summer where plaintiffs were considering</p> <p>17 filing a failing firm defense, a motion for summary judgment</p> <p>18 to preclude that defense.</p> <p>19 The additional factor, Your Honor, that counsel is</p> <p>20 heavily -- in our renewing this objection is that prior to</p> <p>21 the transaction closing, St. Luke's counsel represented to</p> <p>22 both the Federal Trade Commission and the Idaho Attorney</p> <p>23 General that unwinding this transaction would be neither</p> <p>24 costly, nor burdensome. And they made that representation</p> <p>25 essentially as a way to get the Idaho Attorney General and</p>

<p>3112</p> <p>1 the Federal Trade Commission to stand down and not challenge</p> <p>2 the closing of the transaction.</p> <p>3 We believe that that's exactly what they're doing here.</p> <p>4 They are arguing that unwinding the deal will be costly and</p> <p>5 burdensome to Saltzer. And we respectfully suggest that we</p> <p>6 think they should be estopped from making those arguments,</p> <p>7 given the representations they made to the government</p> <p>8 plaintiffs back in December.</p> <p>9 And I just want to renew the objection, Your Honor, and</p> <p>10 suggest that you'll be hearing more from the government</p> <p>11 plaintiffs.</p> <p>12 THE COURT: And I understand that. The problem is</p> <p>13 that the same evidence can be used for different purposes.</p> <p>14 Mr. Bierig, in fact, I think made the point that the</p> <p>15 stipulation was -- and this is something I'm going to have</p> <p>16 to sort out in the decision -- but the stipulation or the</p> <p>17 representation of the court was that they would not put</p> <p>18 forward any argument that the merger itself from the point</p> <p>19 going forward from the date of deposition and the</p> <p>20 consolidation of those relationships would not be raised as</p> <p>21 a -- as a grounds for the court not to undo the transaction.</p> <p>22 But I don't think that would preclude them from -- and I</p> <p>23 didn't understand that would preclude them from arguing that</p> <p>24 what the position of the parties was at the time of the</p> <p>25 court's decision would not be relevant.</p>	<p>3113</p> <p>1 Now, that then leads into the flailing or failing firm</p> <p>2 or failing company defense that you've mentioned. That's</p> <p>3 not on the table, as I understand it. That's not been</p> <p>4 asserted as such. However, the economic circumstances of</p> <p>5 the parties can be considered by the court.</p> <p>6 You know, one of the issues raised, I think, by</p> <p>7 Dr. Argue was whether or not Saltzer would be able to go</p> <p>8 forward with some type of a risk-based or integrated care</p> <p>9 system without aligning itself. That clearly is going to</p> <p>10 depend in part upon whatever the economic circumstances of</p> <p>11 Saltzer was or was not.</p> <p>12 So I fully intend to honor the -- I guess, the parties'</p> <p>13 understanding that neither St. Luke's nor Saltzer will be</p> <p>14 allowed to argue that there has been -- that anything that</p> <p>15 has occurred since the date of the court's decision has</p> <p>16 somehow made it more difficult to unwind the arrangement.</p> <p>17 That's simply not on the table because of counsel's</p> <p>18 representation.</p> <p>19 And, likewise, the failing firm defense is not on the</p> <p>20 table. It's going to require some navigation by the court</p> <p>21 as I go through the evidence, because much of the</p> <p>22 evidence -- I mean, not much. There has been considerable</p> <p>23 evidence on issues that could support both of those</p> <p>24 arguments, but I think they're being offered for different</p> <p>25 purposes. I can just offer you my assurances that they will</p>
<p>3114</p> <p>1 not be considered for reasons which have been excluded from</p> <p>2 the case, either by agreement or by representation.</p> <p>3 Now, Mr. Bierig, did you want to add?</p> <p>4 MR. BIERIG: I would just add, Your Honor, that</p> <p>5 since we had that colloquy last week, I went back and looked</p> <p>6 at my representations to the court at the preliminary</p> <p>7 injunction hearing, and I'm very happy to stand on the</p> <p>8 representations I made. That hearing, when Your Honor</p> <p>9 reviews the transcript of that hearing, I think the court</p> <p>10 will find that what I said is we would not argue that it</p> <p>11 would be physically impossible to -- to undo the merger, as</p> <p>12 it's called -- we don't refer to it as a merger, as this</p> <p>13 court knows -- that we would not argue that it would be</p> <p>14 impossible because there was so much intertwining of</p> <p>15 St. Luke's and Saltzer in the interim. And Your Honor</p> <p>16 specifically got me to make a representation that we would</p> <p>17 not put Saltzer on the Epic system, which we have honored.</p> <p>18 And we also said that we would not use any changed</p> <p>19 circumstances that occurred from the time of the preliminary</p> <p>20 injunction to today to argue that the merger, or the</p> <p>21 affiliation rather, should not be undone, and I don't think</p> <p>22 anything that we've said in this court has been contrary to</p> <p>23 that.</p> <p>24 So I would urge the court, when the court is examining</p> <p>25 this issue, to look at precisely what I said at the</p>	<p>3115</p> <p>1 preliminary injunction because I think that we have been</p> <p>2 totally consistent with the representations that I made.</p> <p>3 THE COURT: Well, I will certainly do so, but my</p> <p>4 impression was that we would -- speaking of unwinding, we</p> <p>5 would unwind the clock, and the court's decision would be</p> <p>6 based upon whatever the economic circumstances of the</p> <p>7 parties at the time of the preliminary injunction hearing.</p> <p>8 So the things that have occurred since generally would not</p> <p>9 be relevant to any issue concerning difficulty of unwinding</p> <p>10 or undoing the arrangement, but whatever the circumstances</p> <p>11 were at that point in time may be considered by the court.</p> <p>12 Now, that was essentially my impression.</p> <p>13 MR. BIERIG: I think that impression is entirely</p> <p>14 correct, Your Honor. And I think there's two aspects to it:</p> <p>15 There's the economics, and then there is sort of the</p> <p>16 intertwining. And the court asked us to take steps to make</p> <p>17 sure that Saltzer would not be so much more integrated into</p> <p>18 St. Luke's that it could no longer be unscrambled.</p> <p>19 That has actually turned out to be an -- you know, an</p> <p>20 unfortunate development from our point of view in terms of</p> <p>21 moving forward to the goals that we're trying to achieve,</p> <p>22 but we have scrupulously honored that representation to the</p> <p>23 court.</p> <p>24 THE COURT: All right. Mr. Wilson.</p> <p>25 MR. WILSON: Briefly, Your Honor. That nuance was</p>

<p style="text-align: right;">3116</p> <p>1 not made to the government in St. Luke's counsel's</p> <p>2 representations to us. In a letter dated December 20th,</p> <p>3 2012, from Mr. Bierig to Mr. DeLange and Stuart Hirschfield</p> <p>4 from the Federal Trade Commission, which has been admitted</p> <p>5 in evidence as Defendants' Trial Exhibit 2625, Mr. Bierig</p> <p>6 said, quote, St. Luke's will not argue in any subsequent</p> <p>7 challenge to the Saltzer transaction that the transaction</p> <p>8 should not be unwound because doing so would be costly or</p> <p>9 burdensome.</p> <p>10 Now, he does go on to state in the next sentence that,</p> <p>11 in particular, they won't argue that efforts at integration</p> <p>12 will be costly or burdensome to unwind, but the statement he</p> <p>13 makes is quite broad. And really it's two sides of the same</p> <p>14 coin, arguing that Saltzer needs St. Luke's financial</p> <p>15 resources to do this risk-based contracting, or the other</p> <p>16 side of the coin being St. Luke's -- or I'm sorry. Saltzer</p> <p>17 without St. Luke's is financially unable to -- would be</p> <p>18 financially unable to continue if it's unwound.</p> <p>19 And we think, to the extent the argument is that, that</p> <p>20 flies in the face -- certainly the spirit, if not the</p> <p>21 letter -- of the representation that was made to the</p> <p>22 government by Mr. Bierig, essentially, to get the government</p> <p>23 to stand down in December.</p> <p>24 THE COURT: All right. Well --</p> <p>25 MR. WILSON: We're not going to resolve it now; I</p>	<p style="text-align: right;">3117</p> <p>1 understand that, Your Honor.</p> <p>2 THE COURT: We're not. Let's -- you know, perhaps</p> <p>3 in your posttrial submissions --</p> <p>4 MR. WILSON: Right.</p> <p>5 THE COURT: -- we'll take it up at that time. I</p> <p>6 think at this point, I've made my ruling. I'm going to</p> <p>7 allow the evidence in because I think it has potentially</p> <p>8 additional relevance beyond the matters which have been</p> <p>9 taken off the table. So you have a standing objection if</p> <p>10 that's necessary, and we'll just move on.</p> <p>11 Mr. Bierig, was there anything else?</p> <p>12 MR. BIERIG: Well, since Your Honor has ruled, I</p> <p>13 think I could probably say nothing further, but we will have</p> <p>14 plenty to say about the complete misrepresentation of the</p> <p>15 statements made in that letter.</p> <p>16 THE COURT: I fully anticipate that I will hear</p> <p>17 about it in the posttrial submissions. And then to the</p> <p>18 extent I need to either reconsider or reaffirm my prior</p> <p>19 decision and my trial rulings concerning what I'm allowing</p> <p>20 and not allowing in evidence, I'll take that up as well.</p> <p>21 That's the beauty of a court trial is I can always undo any</p> <p>22 harm that may have been done by simply not considering</p> <p>23 certain types of evidence that I did allow to be presented.</p> <p>24 Go ahead and proceed, Mr. Wilson.</p> <p>25 MR. WILSON: Thank you, Your Honor.</p>
<p style="text-align: right;">3118</p> <p>1 CROSS-EXAMINATION</p> <p>2 BY MR. WILSON:</p> <p>3 Q. Good afternoon, Mr. Savage.</p> <p>4 A. Good afternoon.</p> <p>5 Q. Is it fair to say that in the years leading up to</p> <p>6 Saltzer's deal with St. Luke's, that Saltzer was becoming</p> <p>7 more and more frustrated in its negotiations with health</p> <p>8 insurance companies?</p> <p>9 MR. KEITH: Objection to form, Your Honor. Beyond</p> <p>10 the scope.</p> <p>11 MR. WILSON: Your Honor, Mr. Keith specifically</p> <p>12 asked Mr. Savage a few questions at the beginning of his</p> <p>13 examination about the motivations for doing the deal. He</p> <p>14 asked him if Saltzer approached St. Luke's or the other way</p> <p>15 around. He also asked Mr. Savage what factored into the</p> <p>16 motivations for the agreement, asking him questions about</p> <p>17 ancillary services and Medicaid patients, for example.</p> <p>18 THE COURT: If your question was essentially an</p> <p>19 entree to get back into that line, I'll allow it, but --</p> <p>20 MR. WILSON: That's right.</p> <p>21 THE COURT: -- I think to go and explore in any</p> <p>22 detail the frustration that Saltzer may have had in</p> <p>23 negotiating with health insurance companies, that I don't</p> <p>24 think was covered by Mr. Keith. So you can use this as a</p> <p>25 springboard to get into an area that's within the scope of</p>	<p style="text-align: right;">3119</p> <p>1 direct, but you need to do so fairly quickly.</p> <p>2 MR. WILSON: Understood.</p> <p>3 THE COURT: Mr. Keith, do you wish to add?</p> <p>4 MR. KEITH: Only that I specifically articulated</p> <p>5 as I was asking the questions that I was not going to get</p> <p>6 into the reasons why Saltzer entered into the transaction.</p> <p>7 I asked two specific questions. One was on who approached</p> <p>8 whom, which I don't think goes to the issue that counsel</p> <p>9 wishes to raise here. And the other was very specific as to</p> <p>10 whether ancillary services were included in the calculation</p> <p>11 of compensation.</p> <p>12 Neither of those goes back to the motivating factors</p> <p>13 for the transaction in the first place, so I'm not sure this</p> <p>14 even works as a segue back into what I have asked on direct.</p> <p>15 THE COURT: Well, I'm going to give counsel some</p> <p>16 leeway, and we'll see where we end up.</p> <p>17 MR. WILSON: It's purely to go to what factored</p> <p>18 into the motivation and discussion of the agreement, which</p> <p>19 is what he asked about, so --</p> <p>20 MR. KEITH: I think that is what Your Honor said</p> <p>21 he should not be getting back into. That is, if he has</p> <p>22 questions about specific -- about the specific questions I</p> <p>23 asked about, who approached whom and the -- whether</p> <p>24 ancillary services played into any compensation, I can</p> <p>25 understand that.</p>

<p style="text-align: right;">3120</p> <p>1 But it sounds like, in fact, counsel wants to ask</p> <p>2 broadly what were the motivating factors that led Saltzer to</p> <p>3 get into -- to enter into the transaction. And I</p> <p>4 specifically avoided those questions.</p> <p>5 MR. WILSON: Your Honor?</p> <p>6 THE COURT: Mr. Wilson.</p> <p>7 MR. WILSON: What Mr. Keith is suggesting is that</p> <p>8 he can ask with a scalpel one particular factor that may</p> <p>9 have gone into the discussions for the agreement, but I am</p> <p>10 precluded from asking about other factors that may have gone</p> <p>11 into those discussions. That's all I'm trying to do.</p> <p>12 THE COURT: All right.</p> <p>13 MR. WILSON: And I have three questions,</p> <p>14 Your Honor.</p> <p>15 THE COURT: Mr. Keith, I'm going to allow it.</p> <p>16 Let's move on. Proceed.</p> <p>17 BY MR. WILSON:</p> <p>18 Q. My question, Mr. Savage, was that in the years</p> <p>19 leading up to the deal with St. Luke's, Saltzer was becoming</p> <p>20 more and more frustrated with its negotiations with health</p> <p>21 insurance companies; correct?</p> <p>22 A. I don't think we really engaged in negotiations</p> <p>23 with health insurance companies. And so --</p> <p>24 Q. That's the point; right?</p> <p>25 A. That may be frustrating if you don't get the</p>	<p style="text-align: right;">3121</p> <p>1 opportunity to do that.</p> <p>2 Q. The negotiations were rather one-sided; correct?</p> <p>3 A. Yes.</p> <p>4 Q. And, in fact, Saltzer's reimbursement rates from</p> <p>5 payors were declining; correct?</p> <p>6 A. In real dollars, yes.</p> <p>7 Q. And you thought that those payors really had no</p> <p>8 interest in negotiating with Saltzer on anything other than</p> <p>9 getting Saltzer to sign a contract, basically; correct?</p> <p>10 A. To that point, we hadn't had any -- any</p> <p>11 significant influence.</p> <p>12 Q. With the payors; correct?</p> <p>13 A. With the payors.</p> <p>14 Q. And you thought that if Saltzer combined with a</p> <p>15 hospital system, that would be helpful because the payor</p> <p>16 might negotiate with the hospital system where they would</p> <p>17 not negotiate previously with Saltzer; correct?</p> <p>18 A. That didn't cross my mind for the reason going --</p> <p>19 going to approaching St. Luke's, no.</p> <p>20 Q. You didn't think that combining with a hospital</p> <p>21 system would be helpful to Saltzer as it negotiated with</p> <p>22 payors?</p> <p>23 A. I think then Saltzer wouldn't be negotiating with</p> <p>24 payors. That would be -- that would be the obligation of</p> <p>25 someone else.</p>
<p style="text-align: right;">3122</p> <p>1 Q. Of the hospital system?</p> <p>2 A. They would have the contracts they would</p> <p>3 negotiate.</p> <p>4 Q. Right. And that would be helpful to Saltzer</p> <p>5 because Saltzer -- the hospital system, the larger hospital</p> <p>6 system rather than Saltzer would be the one negotiating with</p> <p>7 the payor; correct?</p> <p>8 A. Saltzer wouldn't have to be involved in</p> <p>9 negotiations.</p> <p>10 Q. You thought that would be helpful; correct?</p> <p>11 MR. JULIAN: Your Honor, this is beyond the scope</p> <p>12 of direct.</p> <p>13 THE WITNESS: I'm not sure I understand "helpful."</p> <p>14 THE COURT: Just a moment, just a moment.</p> <p>15 Counsel, I think we are getting now beyond --</p> <p>16 MR. WILSON: It's my last question, Your Honor.</p> <p>17 THE COURT: Well, even if it's your last question,</p> <p>18 it's beyond the scope.</p> <p>19 (Laughter and simultaneous discussion.)</p> <p>20 MR. WILSON: We can make light of it, Your Honor,</p> <p>21 but I'd appreciate an answer.</p> <p>22 THE COURT: Well, I -- you know, I suppose if you</p> <p>23 want to recall -- well, I don't know if you can on -- well,</p> <p>24 on rebuttal, but I think it is beyond the scope. I'll have</p> <p>25 to sustain the objection.</p>	<p style="text-align: right;">3123</p> <p>1 MR. WILSON: Okay. Nothing further, Your Honor.</p> <p>2 THE COURT: I forgot where we were. Mr. Ettinger,</p> <p>3 I think --</p> <p>4 MR. ETTINGER: I've had my share.</p> <p>5 THE COURT: You had your bite at the apple. All</p> <p>6 right. I'm sorry. I am --</p> <p>7 MR. ETTINGER: Must not have been memorable, I</p> <p>8 guess.</p> <p>9 THE COURT: No. It was. It was. It was,</p> <p>10 actually. I'm sure I probably cannot recite it line and</p> <p>11 verse, but it was.</p> <p>12 Redirect, Mr. Keith.</p> <p>13 REDIRECT EXAMINATION</p> <p>14 BY MR. KEITH:</p> <p>15 Q. Mr. Savage, counsel for the private plaintiffs</p> <p>16 asked you whether the agreement between St. Luke's and</p> <p>17 Saltzer includes a provision whereby St. Luke's would</p> <p>18 essentially loan Saltzer money. Do you recall that</p> <p>19 testimony? Do you recall that question?</p> <p>20 A. Yes.</p> <p>21 Q. And for what purpose under the agreement would</p> <p>22 St. Luke's extend essentially a loan to Saltzer?</p> <p>23 A. If Saltzer chose to cancel the -- terminate the</p> <p>24 agreement.</p> <p>25 Q. And what would those funds be used for?</p>

<p style="text-align: right;">3124</p> <p>1 A. Excuse me. Can you rephrase that, which funds?</p> <p>2 Q. Sure. The loan that St. Luke's would make to</p> <p>3 Saltzer, for what purpose could those funds be used?</p> <p>4 A. To -- specifically, to reacquire the equipment.</p> <p>5 Q. So could -- could those funds be used simply to</p> <p>6 increase the salaries of the Saltzer physicians to</p> <p>7 compensate for the additional overhead?</p> <p>8 A. It's my recall from the agreement that those funds</p> <p>9 are specifically designated to reacquire the equipment.</p> <p>10 Q. And counsel for the private plaintiffs also asked</p> <p>11 a number of questions about whether there had been</p> <p>12 significant effort expended on generating a contingency plan</p> <p>13 in the event that the court unwound the transaction.</p> <p>14 And my question is: Why? Why has Saltzer not expended</p> <p>15 or conducted a formal process with consultants and the like</p> <p>16 to devise a plan in the event of an unwind?</p> <p>17 A. We don't exactly know what the conditions would be</p> <p>18 of an unwind, if we would be totally forbidden from dealing</p> <p>19 with either system. We didn't know what scenarios to draw.</p> <p>20 Q. And is there, in your mind, a realistic plan for</p> <p>21 keeping Saltzer together in the event of an unwind if</p> <p>22 the -- if the court orders Saltzer not to enter into</p> <p>23 agreements with -- other agreements with St. Luke's or Saint</p> <p>24 Alphonsus?</p> <p>25 MR. ETTINGER: Objection, Your Honor. I don't</p>	<p style="text-align: right;">3125</p> <p>1 think there is any lack of foundation. We've established</p> <p>2 they have not seriously considered it, so how the witness</p> <p>3 can opine about whether it's doable, I don't know.</p> <p>4 MR. KEITH: Well, he's the CEO of the group, and</p> <p>5 I'm asking for his personal opinion. He understands</p> <p>6 Saltzer's finances. I think he can testify as to that.</p> <p>7 THE COURT: But if it wasn't considered, why is it</p> <p>8 relevant?</p> <p>9 MR. KEITH: Well, Your Honor, I'm -- I'm trying to</p> <p>10 get at the point that one reason there is not a formal</p> <p>11 contingency plan is that the -- the -- there is not a good</p> <p>12 option for rescuing the group in the event of an unwind, so</p> <p>13 planning for the downing of the Titanic may not be a good</p> <p>14 use of resources.</p> <p>15 THE COURT: Well, that sounds a lot like a failing</p> <p>16 firm defense, Mr. Keith. I'm a little nervous that -- well,</p> <p>17 Counsel, again, just to keep the record clear, I'm going to</p> <p>18 allow it, but to be -- to offer the testimony. But to me,</p> <p>19 that sounds an awful lot like exactly the defense which I</p> <p>20 understood was not part of the case.</p> <p>21 MR. KEITH: It is --</p> <p>22 THE COURT: So let's just keep the record so it's</p> <p>23 there, but I have -- at this point, have no intention of</p> <p>24 considering it. We'll just essentially treat it as a</p> <p>25 proffer.</p>
<p style="text-align: right;">3126</p> <p>1 Go ahead and proceed.</p> <p>2 MR. KEITH: And, I understand, Your Honor. I</p> <p>3 would not have asked it, and didn't ask it, except</p> <p>4 Mr. Ettinger raised it on his cross.</p> <p>5 THE COURT: I understand. Let's go ahead and --</p> <p>6 BY MR. KEITH:</p> <p>7 Q. So, in your mind, is there a viable plan for</p> <p>8 keeping Saltzer together in the event of an unwind?</p> <p>9 A. No.</p> <p>10 MR. KEITH: Thank you, Your Honor. No further</p> <p>11 questions.</p> <p>12 THE COURT: Mr. Ettinger.</p> <p>13 MR. ETTINGER: Since the door is opened,</p> <p>14 Your Honor, I have to walk through it just a little bit</p> <p>15 more.</p> <p>16 RE-CROSS-EXAMINATION</p> <p>17 BY MR. ETTINGER:</p> <p>18 Q. So let me just make sure I'm clear, Mr. Savage.</p> <p>19 You've not substantively discussed a contingency plan. When</p> <p>20 asked in June why you hadn't, you didn't know. And yet</p> <p>21 you're, nevertheless, quite sure that there is no such plan</p> <p>22 possible. Do I have it right?</p> <p>23 A. It's my opinion --</p> <p>24 Q. Do I have that right? Yes or no.</p> <p>25 A. Would you repeat what I have right?</p>	<p style="text-align: right;">3127</p> <p>1 Q. You've never substantively discussed a contingency</p> <p>2 plan. You've never hired consultants to consider it. When</p> <p>3 I asked you in June why not, you said, "I don't know." And,</p> <p>4 nevertheless, today in response to Mr. Keith, you say that</p> <p>5 it's impossible to develop one. Do I have that right? Yes</p> <p>6 or no.</p> <p>7 A. Yes.</p> <p>8 MR. ETTINGER: Nothing further.</p> <p>9 THE COURT: Mr. Wilson, anything else?</p> <p>10 MR. WILSON: No, thank you, Your Honor.</p> <p>11 MR. KEITH: Nothing further.</p> <p>12 THE COURT: All right. You may step down.</p> <p>13 THE WITNESS: Thank you.</p> <p>14 THE COURT: Mr. Savage, thank you.</p> <p>15 Call your next witness.</p> <p>16 MR. SCHAFER: Your Honor, we call Gregory</p> <p>17 Sonnenberg by his video deposition.</p> <p>18 THE COURT: Counsel, did we work out getting</p> <p>19 Dr. Sonnenberg available for cross by -- as a live witness?</p> <p>20 Was that worked out?</p> <p>21 MR. SCHAFER: Yes, Your Honor. It's my</p> <p>22 understanding he is available.</p> <p>23 THE COURT: And we will publish the deposition of</p> <p>24 Dr. Sonnenberg.</p> <p>25 MR. ETTINGER: Your Honor, among other things, we</p>

<p style="text-align: right;">3128</p> <p>1 prefer he not be promoted; he is not a doctor.</p> <p>2 THE COURT: Oh. Well, you know, I have been doing</p> <p>3 that all through this trial. Mr. Savage just got -- of</p> <p>4 course, some might not call that a promotion.</p> <p>5 Just a moment. Before we start, though, let's go ahead</p> <p>6 and allow Ms. Gearhart to publish the deposition of</p> <p>7 Mr. Sonnenberg.</p> <p>8 THE CLERK: The deposition of Gregory Sonnenberg</p> <p>9 taken on April 18, 2013, is published.</p> <p>10 MR. SCHAFER: And, Your Honor, with respect to</p> <p>11 AEO, there's 16 minutes of a little -- you know, it's</p> <p>12 roughly half of this is AEO, and it's scattered, so I don't</p> <p>13 know. It's up to Your Honor's preference whether you want</p> <p>14 to keep --</p> <p>15 THE COURT: Well, the only way, if you can turn</p> <p>16 off -- if turning off the monitor will be sufficient, that</p> <p>17 would be my preference, but I can't judge that. You're</p> <p>18 going to have to -- is it Saint Al's?</p> <p>19 MR. SCHAFER: Saint Al's AEO. And I don't believe</p> <p>20 it's limited to documents, Your Honor. I think it's the</p> <p>21 testimony itself that was --</p> <p>22 THE COURT: Ms. Duke?</p> <p>23 MS. DUKE: There is a very healthy portion of the</p> <p>24 first several, several pages that is not AEO, so I think</p> <p>25 that I can tell you when we need to blank it out, and then</p>	<p style="text-align: right;">3129</p> <p>1 there will be a point where it makes sense to clear</p> <p>2 St. Luke's.</p> <p>3 THE COURT: All right. Let's do that. Let's -- I</p> <p>4 assume you can or will communicate that to Mr. Schafer or</p> <p>5 whoever is at the wheel.</p> <p>6 MS. DUKE: He has the same chart I do, so at</p> <p>7 51:22, we'll need to blank the, you know --</p> <p>8 MR. SCHAFER: I have got where to blank it.</p> <p>9 MS. DUKE: Right.</p> <p>10 THE COURT: Okay.</p> <p>11 MR. SCHAFER: When we get to the AEO, we can --</p> <p>12 THE COURT: So are we just going to blank the</p> <p>13 screen or clear the courtroom?</p> <p>14 MR. SCHAFER: I think we can blank the screen,</p> <p>15 Your Honor, until we get about halfway through. And then</p> <p>16 it's all AEO from there till the end, so it might be easier</p> <p>17 to just start with it open and pause it later.</p> <p>18 THE COURT: Okay. So blank the screen now, or</p> <p>19 will you tell me when to do so?</p> <p>20 MS. DUKE: We'll tell you when.</p> <p>21 MR. SCHAFER: We'll tell you when to do so.</p> <p>22 THE COURT: Very good.</p> <p>23 (Testimony of Gregory Sonnenberg via video deposition.)</p> <p>24 (Video deposition paused.)</p> <p>25 MR. SCHAFER: Your Honor, we need to turn the</p>
<p style="text-align: right;">3130</p> <p>1 screen off for this next.</p> <p>2 THE COURT: All right. Thank you.</p> <p>3 (Video deposition resumed.)</p> <p>4 (Video deposition paused.)</p> <p>5 MR. SCHAFER: Your Honor, I think we can turn the</p> <p>6 screen back on.</p> <p>7 (Video deposition resumed.)</p> <p>8 (Video deposition paused.)</p> <p>9 MR. SCHAFER: Your Honor, the rest of</p> <p>10 Mr. Sonnenberg is going to be AEO, so this is probably --</p> <p>11 THE COURT: All right. I'll request --</p> <p>12 MR. SCHAFER: -- a good time to clear the</p> <p>13 courtroom.</p> <p>14 THE COURT: I'll request, then, that anyone not</p> <p>15 having been designated as allowed to remain because they've</p> <p>16 signed the protective order in this matter will be required</p> <p>17 to leave the courtroom.</p> <p>18 *****COURTROOM CLOSED TO THE PUBLIC*****</p> <p>19 (Continued testimony of Gregory Sonnenberg via video</p> <p>20 deposition.)</p> <p>21 (Video deposition of Gregory Sonnenberg concluded.</p> <p>22 MR. SCHAFER: Your Honor, that's the end of</p> <p>23 Mr. Sonnenberg.</p> <p>24 THE COURT: All right. Do you have another --</p> <p>25 MR. SCHAFER: We do. We've got one that's roughly</p>	<p style="text-align: right;">3131</p> <p>1 ten minutes, Your Honor. And it's mostly AEO, so --</p> <p>2 THE COURT: It is all AEO?</p> <p>3 MR. SCHAFER: Yes, 70 percent or so.</p> <p>4 THE COURT: Let's go ahead and play it, then.</p> <p>5 MR. SCHAFER: It's Jeffrey Hessing.</p> <p>6 THE COURT: We'll publish the deposition of</p> <p>7 Mr. Hessing. It looks like --</p> <p>8 MS. DUKE: This one would be a doctor, Your Honor,</p> <p>9 Dr. Hessing.</p> <p>10 THE COURT: I'm sorry?</p> <p>11 MS. DUKE: Dr. Hessing.</p> <p>12 THE COURT: Dr. Hessing. I should have an</p> <p>13 intimate familiarity with the entire medical community of</p> <p>14 Treasure Valley, but I don't.</p> <p>15 THE CLERK: The deposition of Jeffrey Hessing</p> <p>16 taken April 29th, 2013, is published.</p> <p>17 THE COURT: Mr. Schafer.</p> <p>18 (Testimony of Jeffrey Hessing via video deposition.)</p> <p>19 MR. SCHAFER: Your Honor, that's the end of the</p> <p>20 clip for Mr. Hessing.</p> <p>21 THE COURT: Counsel, I believe Exhibit 2064 was</p> <p>22 referenced. There was a relevance and hearsay objection</p> <p>23 noted. Is that withdrawn?</p> <p>24 MR. POWERS: No, we're maintaining those,</p> <p>25 Your Honor.</p>

<p style="text-align: right;">3132</p> <p>1 MR. SCHAFER: That was on Sonnenberg; you know</p> <p>2 that.</p> <p>3 MR. POWERS: Oh, I thought --</p> <p>4 MR. SCHAFER: 2064 was on Sonnenberg.</p> <p>5 MR. POWERS: Sorry.</p> <p>6 MS. DUKE: We are maintaining those, Your Honor.</p> <p>7 It's a CV of Mr. Sonnenberg and, I mean, no CVs of any of</p> <p>8 the other fact witnesses have been admitted. While he may</p> <p>9 have been interviewing for a job during that, that</p> <p>10 deposition --</p> <p>11 THE COURT: So you're probably going to offer it</p> <p>12 when you cross-examine him, then, so perhaps.</p> <p>13 Counsel, do we really need to have that?</p> <p>14 MR. STEIN: Well, it was offered, actually, for</p> <p>15 the truth of certain statements -- he testified about</p> <p>16 certain statements that he made in there as a representative</p> <p>17 for --</p> <p>18 THE COURT: That's true, Counsel. There were</p> <p>19 statements made in the CV.</p> <p>20 MS. DUKE: But he's saying those in his testimony.</p> <p>21 THE COURT: That's true.</p> <p>22 MS. DUKE: I mean, it's cumulative.</p> <p>23 THE COURT: Counsel, I don't know why we need the</p> <p>24 exhibit, because he orally confirmed those statements. So I</p> <p>25 think I'll sustain the objection just to be consistent and</p>	<p style="text-align: right;">3133</p> <p>1 so we're not dragging in all of the CVs. All right.</p> <p>2 MR. SCHAFER: I think there was one document</p> <p>3 referenced in Hessing, Your Honor, 2104, to which -- it was</p> <p>4 probably the one Mr. Powers was referring to, the one</p> <p>5 document that TVH had an objection to. And it sounds like</p> <p>6 they still do.</p> <p>7 MR. POWERS: We do, Your Honor. I think we object</p> <p>8 on the grounds that it falls within the motion in limine</p> <p>9 that you granted with respect to negotiations by Saint Al's</p> <p>10 with Saltzer.</p> <p>11 THE COURT: Counsel, is there some other</p> <p>12 independent relevance of that exchange, that email exchange?</p> <p>13 MR. STEIN: Yes. Well, there were a couple of</p> <p>14 things. Well, primarily, first of all, with respect to why</p> <p>15 the Saltzer surgeons are not part of Saltzer and the</p> <p>16 representations that were just discussed and relating to</p> <p>17 Ms. Jeffcoat, Saint Al's CEO, telling them that they would</p> <p>18 have enough referrals if they didn't come forward. So I</p> <p>19 think it's -- it's, again, relevant to this foreclosure</p> <p>20 issue.</p> <p>21 THE COURT: Response, Mr. Powers?</p> <p>22 MR. POWERS: No additional response, Your Honor.</p> <p>23 THE COURT: Well, I guess I'll overrule the</p> <p>24 objection to the extent -- let me review that. If counsel</p> <p>25 can provide me with a copy of the -- if you have a hard copy</p>
<p style="text-align: right;">3134</p> <p>1 of the deposition excerpt so I can see the context and what</p> <p>2 testimony was provided, as well as the exhibit, then I'll</p> <p>3 rule on that and announce my ruling tomorrow. Give me a</p> <p>4 chance to look at it. I -- the problem was that the</p> <p>5 objection -- I didn't track the objection at the time the</p> <p>6 testimony was being offered, and so I need to have that to</p> <p>7 put it in context.</p> <p>8 MR. SCHAFER: We'll provide that, Your Honor.</p> <p>9 THE COURT: Great.</p> <p>10 MR. SCHAFER: And I had one other question with</p> <p>11 respect to expert demonstratives. We had some question as</p> <p>12 we go through the AEO process. We understood that</p> <p>13 Your Honor would be taking these expert demonstratives for</p> <p>14 your review. But what we wanted to know was: Are those</p> <p>15 going to be made part of the public record such that we need</p> <p>16 to review those and make AE -- you know, submit an affidavit</p> <p>17 with our AEO designations with respect to specific slides,</p> <p>18 or will that just be for your review in camera?</p> <p>19 THE COURT: I think, since many of the slides were</p> <p>20 referenced to exhibits which presumably were identified as</p> <p>21 AEO, counsel can just stand on whatever you've submitted</p> <p>22 with regard to that. I do think that they should be made</p> <p>23 available to the public since they were presented in the</p> <p>24 courtroom, and I'll essentially make the same ruling on</p> <p>25 those.</p>	<p style="text-align: right;">3135</p> <p>1 If there was not something provided by way of an</p> <p>2 affidavit concerning the underlying exhibits, you'll need to</p> <p>3 independently provide us with an affidavit as to why the</p> <p>4 information on the slide constitutes AEO. All right?</p> <p>5 MR. SCHAFER: Understood.</p> <p>6 THE COURT: Good.</p> <p>7 Anything else?</p> <p>8 MR. STEIN: Well, sorry for the tag-teaming here,</p> <p>9 but so we're now getting down incredibly to the last couple</p> <p>10 of days, and so tomorrow we will be finishing with our live</p> <p>11 testimony. There is still some deposition testimony, and we</p> <p>12 understand that the court would prefer that if we finish</p> <p>13 with the live testimony tomorrow, we not spend the rest of</p> <p>14 Friday afternoon, as enjoyable as that would be, watching</p> <p>15 videos.</p> <p>16 I guess what we would like to do -- we understand that</p> <p>17 plaintiffs won't make a final decision about their rebuttal</p> <p>18 case, but we understand they could have as many as four or</p> <p>19 five rebuttal witnesses. And, obviously, we want to be</p> <p>20 sensitive to reserving our time so as to have sufficient</p> <p>21 time to cross-examine them on Monday.</p> <p>22 And so I think what we would like to do, if it's all</p> <p>23 right with the court, is once we finish the live testimony</p> <p>24 is that, as I understand, when plaintiffs will disclose</p> <p>25 their rebuttal witnesses and then maybe take a day or so to</p>

<p>3136</p> <p>1 figure out what we want to do with respect to the remaining</p> <p>2 depositions to ensure that we don't run out of time to</p> <p>3 cross-examine their witnesses on Monday. And then we would</p> <p>4 provide the court Saturday or Sunday, if the court were</p> <p>5 actually going to review the videos then, with the remaining</p> <p>6 deposition videos and transcripts.</p> <p>7 Alternatively, we could do that on Monday if the court</p> <p>8 would intend to, you know, view them or review them.</p> <p>9 THE COURT: I can't promise I'll look at them over</p> <p>10 the weekend, but I may.</p> <p>11 Mr. Wilson?</p> <p>12 MR. WILSON: Only that there are counters,</p> <p>13 obviously, within those designations, and so we would just</p> <p>14 need to know prior to putting our witnesses on how much time</p> <p>15 we actually -- it is getting very close, and so even 20 or 5</p> <p>16 minutes of counter-designations could make a difference.</p> <p>17 MS. DUKE: But we would want to know this weekend,</p> <p>18 is ultimately -- I mean, they're going to know our rebuttal</p> <p>19 witnesses tomorrow after they are finished with their last</p> <p>20 live witness.</p> <p>21 THE COURT: Look at that over the weekend, provide</p> <p>22 that information to counsel. I'm not going to review them</p> <p>23 over the weekend, but I think counsel needs to know so you</p> <p>24 can apportion your time accordingly.</p> <p>25 MR. STEIN: And if we -- as far as Monday goes, if</p>	<p>3137</p> <p>1 we go over -- or is there any flexibility in the 2:30</p> <p>2 deadline --</p> <p>3 THE COURT: There is.</p> <p>4 MR. STEIN: -- so that we can finish?</p> <p>5 THE COURT: The only thing to keep in mind is that</p> <p>6 Ms. Hohenleitner and I both need to be in Pocatello Tuesday</p> <p>7 morning to start a very long calendar.</p> <p>8 MR. STEIN: Back-to-back.</p> <p>9 THE COURT: So I'm not anxious to be here</p> <p>10 certainly after 5:00. And the air connections between here</p> <p>11 and Pocatello are essentially nonexistent or very indirect.</p> <p>12 So I think, given that, we would very much appreciate being</p> <p>13 done, say, by, you know, maybe 3:30 or something along those</p> <p>14 lines.</p> <p>15 Now, we also -- the plaintiffs have not rested, and I</p> <p>16 know that we need to at some point -- before the defense</p> <p>17 rests, we have to have the plaintiffs rest. I think that's</p> <p>18 usually the order these things come in. And I understand</p> <p>19 that counsel is just chomping at the bit to argue their</p> <p>20 Rule 52 motions.</p> <p>21 MR. JULIAN: And, actually, Your Honor, after</p> <p>22 reviewing the record, we feel that we can protect ourselves</p> <p>23 posttrial, so we won't be taking up any of the court's time</p> <p>24 with that.</p> <p>25 THE COURT: All right. Then we'll just wait until</p>
<p>3138</p> <p>1 an appropriate time for the plaintiffs to rest and then</p> <p>2 allow the defendants to formally make their Rule 52 motion,</p> <p>3 and then we'll take it up posttrial.</p> <p>4 MS. DUKE: And the only thing that's, I think at</p> <p>5 this point, keeping us from closing is there is this exhibit</p> <p>6 issue that I know Mr. Metcalf chatted with you about. It's</p> <p>7 our understanding that you have asked for written</p> <p>8 submissions related to that.</p> <p>9 What we were going to provide is a spreadsheet that</p> <p>10 Mr. Su has put together that provides each and every</p> <p>11 exhibit, what the objections are, and when foundation was</p> <p>12 needed through depositions or something like that through</p> <p>13 the deposition testimony. So we were just going to submit</p> <p>14 that chart to Your Honor so you could look at it that way.</p> <p>15 Is that sufficient?</p> <p>16 THE COURT: That would be fine.</p> <p>17 MS. DUKE: Thank you.</p> <p>18 THE COURT: Mr. Stein, anything else?</p> <p>19 MR. STEIN: No, thank you, Your Honor.</p> <p>20 THE COURT: All right. Counsel, we'll see</p> <p>21 you tomorrow at -- well, we'll take up all of tomorrow until</p> <p>22 2:30; correct?</p> <p>23 MR. STEIN: Well, actually, we may finish our live</p> <p>24 testimony before then. In fact, it's probably likely that</p> <p>25 we'll finish the live -- Mr. Schafer is now giving me a</p>	<p>3139</p> <p>1 look. I think it's likely that we'll finish the live</p> <p>2 testimony before 2:30 tomorrow.</p> <p>3 THE COURT: Let's leave it at that. All right.</p> <p>4 We'll be in recess, then, until 8:30 tomorrow morning.</p> <p>5 (Court recessed at 2:39 p.m.)</p> <p>6</p> <p>7</p> <p>8</p> <p>9</p> <p>10</p> <p>11</p> <p>12</p> <p>13</p> <p>14</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>

REPORTER'S CERTIFICATE

I, Tamara I. Hohenleitner, Official
Court Reporter, County of Ada, State of Idaho,
hereby certify:

That I am the reporter who transcribed
the proceedings had in the above-entitled action
in machine shorthand and thereafter the same was
reduced into typewriting under my direct
supervision; and

That the foregoing transcript contains a
full, true, and accurate record of the proceedings
had in the above and foregoing cause, which was
heard at Boise, Idaho.

IN WITNESS WHEREOF, I have hereunto set
my hand October 31, 2013.

-S-

Tamara I. Hohenleitner
Official Court Reporter
CSR No. 619